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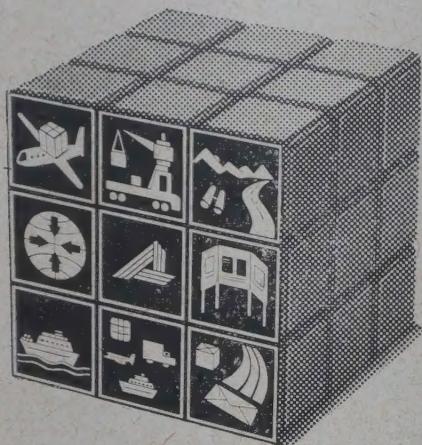
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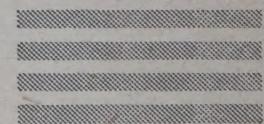
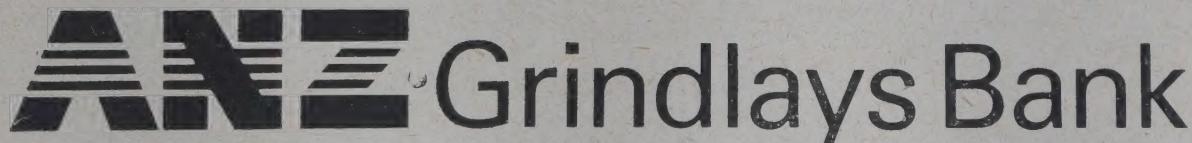
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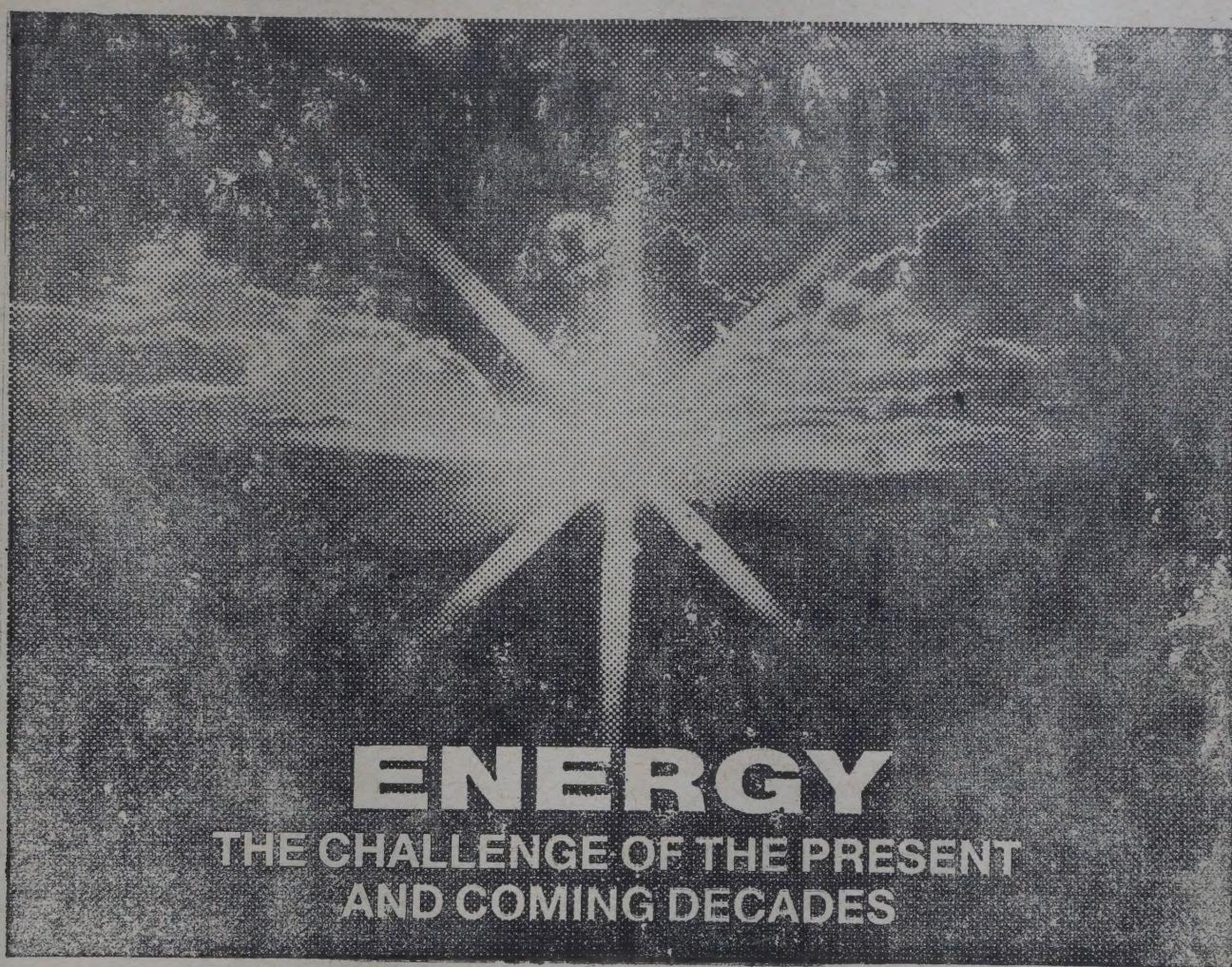
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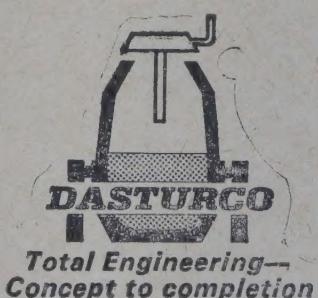
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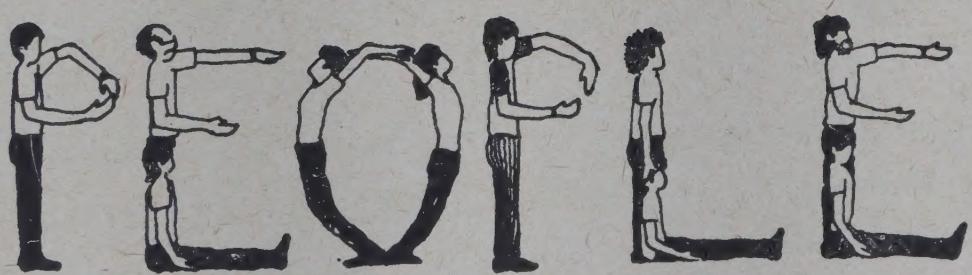
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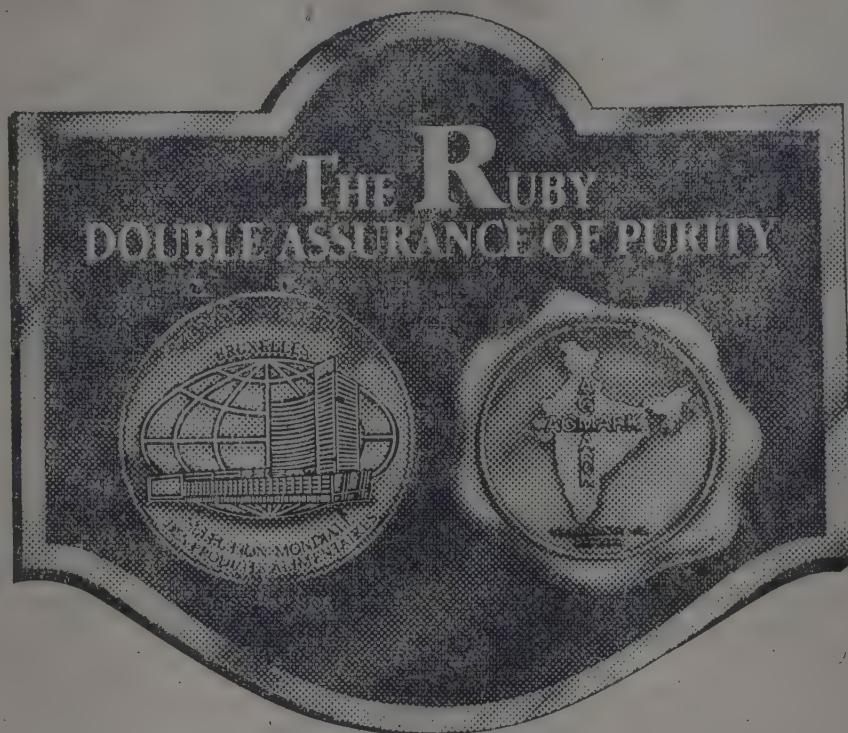
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the state of public
health care

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The problem

INDEPENDENCE came to India in 1947. Unfortunately, freedom from hunger, disease and deprivation did not come for the majority living in this largest democracy in the world, in this country of ours which prides itself in being a Third World leader. The seven five-year plans, while marginally affecting a few areas, left the major health problems unresolved and the people's health status unchanged, while health care costs spiralled and skyrocketed.

In the meantime, there have been committees, commissioners and new programmes. Yet, the most critical and essential aspects have been somehow marginalised, while those that suited the interests of the minority have been implemented. For example, over 110 regular and capitation fee medical colleges were set up, but no effort was made to ensure the ongoing education, monitoring, auditing and building of functional health teams. Increasing commercialisation, pharmaceuticalisation and privatisation of health care has led to irreversible distortions and marginalisation of some of the saner alternatives that existed.

It was quite clear by the early 1980s that health care services for the poor 'were grossly inadequate', the priorities misplaced, and the implementation inadequate and inappropriate. The ICMR, ICSSR report on 'Health for All' — an alternative strategy — had clearly recognised the western, curative care oriented, hospital and doctor centred medical model as inappropriate. Again, though the limitations of vertical programmes and their interference in the implementation of comprehensive primary health programmes were evident, we still continued to have more and more of the same, including the recent technology missions which were launched with great promises and a sense of euphoria. The fate of our national health programmes, especially when seen in the light of the liberalisation and sophistication of privatised medical care, is warning enough about the fate of health in our country.

The infant and maternal mortality rates and other indicators of health have continued to be comparable to those of the poorest nations in the world. None of the national health programmes have really made any impressive headway, including

those that were included in Prime Minister Indira Gandhi's 20-point programme.

Even the national goitre control programme, which should have proved the easiest to handle, and which was launched way back in 1964, failed to deliver iodized salt to those 60 millions afflicted with goitre, and those thousands of mothers who, deprived of iodine in their bodies, gave birth to deaf-mutes, mentally retarded and mentally sub-normal children. All this for want of iodized salt.

It required a writ petition in the Supreme Court by the public litigation lawyer Kapila Hingorani for the sale of uniodized salt in endemic areas to be made illegal. Yet, since no effort was made to make iodized salt cheaper than uniodized salt, the consumption of the latter continued even in endemic areas. Recognising that the iodine deficiency diseases were not being tackled adequately, privatisation of iodized salt production and its popularisation by the Tatas and others was offered as a solution. The import of potassium iodate has now been totally subsidised. Will universal iodization

of salt ensure the availability of iodized salt to those who need it most, in the mountain areas, the terai and the flood-prone areas of east UP and Bihar? Whether such an exercise in universal iodization will merely ensure a larger iodized salt market, only time will tell.

A large number of health and consumer groups in coastal regions are protesting the making of iodized salt consumption mandatory, even in coastal areas and areas where there is no evidence of iodine deficiency. Even if this deficiency exists in small pockets, the rational approach would be to identify the reasons for low iodine presence: flooding, soil erosion and washing away of iodine, sewage contamination, presence of goitrogens in food, or in pesticides and fertilisers.

Many wonder whether the only method of dealing with the IDD problem is really universal iodization. Another approach would perhaps have been better for selected endemic areas — for instance, the adequate production of iodized salt by public sector units, and its streamlined distribution through

the public and private distribution systems at a price much cheaper than that of uniodized salt in the market. Instead of expecting the Tatas to do 'social marketing' of the product, the enthusiastic and creative use of the government's own mass media like AIR and Doordarshan might have been more appropriate.

The planning commission's mid-term evaluation of the family planning programme has shown the obvious: that the FP programme is a failure. Not only did it not succeed in decreasing the birth rate, but due to the priority given to achieving FP targets the entire primary health care work suffered. In fact, the very concept of primary health care suffered as it became increasingly identified with the target oriented FP work.

Much has been said about the target approach of the family planning drives. Because of them not only did other non-targeted health activities, but also the 'life saving' and 'suffering alleviation' ones get completely marginalised. Not surprisingly, the target approach itself developed inherent distortions — a large number of sterilisations were done on those who had already completed their families. The tragic aspect of the programme was that it was not geared to ensure survival of the children, and in many places it was linked with incentives, e.g. in food for work programmes, loans for housing, building of wells etcetera, during the silent drought in Rajasthan and in several tribal and rural areas, where it was the need for the incentives that drove the people to the sterilisation camps and not the conviction or motivation to limit their families.

Failure of the humanised approach in helping women space and control their pregnancy has led to the failure of the programme which till today continues to be a 'government' programme and not a 'people's health programme'.

Where the health of the mother is concerned, sudden interest in her health status when she becomes pregnant after failing to provide adequate nutrition and meeting basic needs right through the period of a woman's development, can never make up for the deficiencies. As Dr Kamla Jairao aptly asks, is it 'the woman or the mother' that we refer to when talking of health care? With 70 per cent of our pregnant mothers anaemic, with antenatal care and facilities for safe childbirth not easily available, maternal mortality continues to be high. The inverse sex ratio further indicates not merely the status of women in our society, but also the status of health care facilities meant for them. It also shows that for MCH (Maternal and Child Health) to be really meaningful, the woman needs proper attention right from the start, not after her nutritional and body development has already been negatively affected. Unfortunately, the target of MCH has never been the number of lives saved or disease episodes treated or prevented. To put it more statistically, the MCH has not been concerned about decreasing the birth rate, maternal mortality or infant morta-

lity, it has been more interested in the number of tubes ligated and IUCD's inserted.

In child health (like FP for mothers) it is the immunisation targets, which should actually form part of a comprehensive child health programme, that have tended to eclipse everything else. It is envisaged that with GOBI FFF (growth monitoring, ORT [Oral Rehydration Therapy], breastfeeding, immunisation, female literacy, fertility control and food supplements) several health problems can be effectively tackled. Growth monitoring can prove to be a futile exercise if low birth weight babies continue to be born to undernourished mothers and if even adequate weaning or other foods are not available.

In absence of the availability of safe drinking water and adequate sewage disposal, ORS (Oral Rehydration Solution), even while being the greatest medical revolution of the century, can only play a partial role in dealing with diarrhoea as a public health problem. If any 'social marketing' is required in diarrhoea care, it should be for ensuring the availability of safe drinking water and encouraging families to initiate early rehydration, that is, return of liquids lost through home fluids. Rational diarrhoea care is not 'sales promotion of ORS packets' from some commercial enterprise, most likely a multinational selling its wares at a subsidised rate and creating a future dependency. Without any serious efforts to demystify the role of fluids and the contents of the ORS packets in the market, and without any effort to withdraw hazardous anti-diarrhoeals, or to educate, build awareness, and issue warnings about irrational and non-essential anti-diarrhoeals—many of which should also be withdrawn—the approach to diarrhoea care cannot be considered rational. A simple structure ensuring that all anti-diarrhoeals carry a consumer caution that 'anti-diarrhoeals are not the main treatment of diarrhoea, it is ORT and this is how to make it' with an accompanying pictorial illustration, can be adopted by our national diarrhoeal disease control programme. The programme must also include measures for decontamination of water. The fate of most national health programmes is not very inspiring. While numerous committees to identify the lacunae in them have met and given their recommendations, these do not seem to have been implemented properly, if they have been implemented at all.

The malaria control programme can never be tackled by anti-malarials, mosquito repellants and insecticides as long as water stagnation and mosquito breeding places are allowed to continue, and as long as we fail to identify and effectively treat those patients who have positive malarial parasites in their blood. Given the spread of cerebral malaria caused by plasmodium vivax and in view of the emerging resistance of the malarial parasite to the normally used anti-malarials and the increasing resistance of the mosquito to pesticides, the malaria problem is bound to take a serious turn.

The increase in filaria, dengue and Japanese B encephalitis is enough indication of our failure to

deal with the vector and vector-borne diseases. 20,000 cases of kalazar—the highest number anywhere in the world—spread by sandfly were apparently diagnosed in Bihar in 1987 alone. Severe shortage of funds, the non-availability of anti-kalazar drugs, the failure in orienting and training government and private medical practitioners in recent approaches to kalazar care have not only led to its further increase, but facilitated its spread into neighbouring states. Since kalazar, too, is a disease of poverty, it is unlikely that it will receive the serious and urgent attention it requires for several years to come.

It is not that major health problems have not been identified, nor that blueprints for tackling them have not been prepared. For example, the National TB control programme has been formulated on the basis of sound epidemiological principles. Yet there is something missing. Perhaps it is an absence of political will. Or perhaps it is sheer apathy and indifference to the suffering of fellow beings, a preference for activities that yield quick, transient results, or greed for profiteering from human suffering. However, the question is that how can such a humanly degrading situation be allowed to carry on—with crores being spent on futile activities—without a strong protest.

We saw uncontrolled diseases of poverty. By the end of 1988, communicable diseases like cholera, dengue, malaria, filaria, Japanese B encephalitis and kalazar had played havoc with our people—the first two in the nation's capital itself. Reports of deaths from gastroenteritis kept pouring in from Gujarat, Kerala, West Bengal and other parts of the country. Instead of tackling these, we continued to congratulate ourselves for eradicating plague and small pox from India.

It was thus with a sense of dismay that many of us realised that it was not just the rise in diseases of industrialisation, the increasing chemicalisation of our environment and ourselves, effluents as highlighted by the Bhopal gas tragedy, the increasing use of pesticides and throwing of chemicals wastes in the rivers that were a cause for concern. It was our complete failure to ensure that past health problems did not continue to wreak havoc even 40 years after we had begun to govern ourselves. The exact magnitude of the health challenge is not quite known.

Bhopal did not merely highlight how easy it is for potentially dangerous industries to be installed just anywhere, including within city limits. It also demonstrated how easy it is for such units to develop unmonitored, flaunting all rules and safety regulations. It is obvious that very little was known about the chemicals and substances being dealt with, that the health machinery was ill-equipped to handle such disasters, and that the medical profession was incapable of dealing with the health hazards. It also showed how unlikely it is that prompt action will be taken to avert such disasters even in the future, with

the victims not being denied justice for years. With increasing environmental awareness in the technologically advanced countries and with the increasing desire of the formulators of this nation's policies to enter the 21st century—it is likely that we will have more of such potentially hazardous industry, unfortunately with little or no functional controls.

The recent report from the Defence Research Laboratory in Gwalior that the Bhopal gas MIC had contained cyanide should make several of those in authority hang their heads in guilt and shame. Their failure to accept this earlier prevented the timely use of sodium thiosulphate, the antidote for cyanide, which could have saved lives and prevented irreversible disability and debilitation.

Sodium thiosulphate (NAC) was recommended in the initial Union Carbide telex. It was also recommended by Dr Daunderer, the expert toxicologist from Germany, and by ICMR following its double blind control trial. The clinical experience of eminent doctors in Bhopal and of the Jan Swasthya Kendra set up by doctors from various voluntary organisations had shown evidence of improvement. Instead of allowing the gas victims to be drugged with antibiotics and steroids of many irrational and hazardous drugs, the timely use of sodium thiosulphate, which was known to be safe and the only potential antidote to MIC poisoning at that time, could have been given the benefit of doubt and it could have saved lives and prevented irreversible damage. No amount of monetary compensation can make up for disability and death.

In contrast to this, at the time of the cholera epidemic two monsoons ago, the entire health machinery in Delhi was mobilised to meet the impossible targets of cholera vaccination. Not only is vaccination useless after the onset of an epidemic, by insisting on it precious resources and manpower were made unavailable for saving the lives of those afflicted with cholera and preventing its spread. Even after receiving cholera vaccines, children continued to die of dehydration because there was no effort to educate the people about the greatest medical revolution of the century, i.e., oral rehydration. Diarrhoea takes 1.5 million lives each year, and is a known baby killer. Diarrhoea deaths of this magnitude indicate apathy and inaction, or inappropriate action, at various levels, even at the time of epidemics, when diarrhoea care is supposed to be provided on a war footing.

The 1980s have clearly shown that where the poor are concerned, they have worse things in stock for them. In policy after policy, their interest has not been safeguarded. While the new drug policy has ensured an increase in the drug prices for the manufacturers, it has failed to ensure the adequate production, distribution and availability of essential and life saving drugs. It has even failed to ensure the withdrawal of hazardous drugs, leave alone the irrational and inessential. The situation is so bad that even the banning of three drugs — high dose estrogen

progesterone, chloramphenicol streptomycin, and steroid combination — was achieved with great difficulty.

The high dose EP drugs were banned after seven years of national campaigning by health consumer and women's groups, and after four public hearings. Chloramphenicol streptomycin combination and steroid combination had been recommended for immediate withdrawal by the government Drug Consultative Committee way back in 1980. Despite the so-called amendment of the Drugs and Cosmetics Acts, the manufacturers of these drugs still have the arrogance and callousness to challenge the ban and obtain stay orders against it.

The issue here is not the obtaining of a stay order against these three drugs. What is of concern is that a system, which allows a greedy few to totally disregard the verdict of the highest authority in the country and the health interest of the people — who are anyway the ones paying the price — should continue to exist unchallenged. It is therefore not surprising that the Rs 400 crores or so ordered by the Supreme Court to be paid by 13 manufacturers for overpricing is nowhere near being paid. It is also not surprising that the Drug Price Equalization Account, under which this payment was to be made when gross drug overpricing was detected, has been altogether deleted in the new drug policy.

The money obtained from the manufacturers indulging in overpricing under the DPEA was to have been used for setting up quality control laboratories and strengthening its machinery. So while the number of pharmaceutical units has increased from 9000 to 20,000 and every fifth drug tested has been found to be substandard — very little has been done by way of ensuring the adequate production of good quality, essential and life-saving drugs at reasonable prices.

Ironically, despite the phenomenal growth of our pharmaceutical industry — one of the most developed in the Third World — so much so that it is exporting drugs to be sold in the world market, the Indian consumer continues to get a raw deal.

— Unavailability of several essential and life-saving drugs, including those for the national health programmes, continues.

— Hazardous, irrational and non-essential health program drugs continue to be sold and promoted unchecked, and without the necessary warning (since the pricing structure makes the production and sales more profitable).

— The quality of drugs and monitoring of adverse drug reactions continues to be poor, the latter being almost non-existent inspite of the Lentin Commission Report.

— Lack of unbiased information for health personnel and consumers by way of a comprehensive National Drug Formulary with therapeutic guide-

lines and 'consumer caution' in regional languages, about potentially hazardous drugs.

— The rise in prices of essential and life-saving drugs for diseases of poverty makes them even more unaffordable to a large percentage of the population.

Medical technologies in the interest of the people somehow never seem to reach them, while pill culture and information about the wonders of tonics and injections manage to reach even the remotest areas very successfully. People also get to know about technologies like amniocentesis, which is being grossly misused for sex determination, so much so that amniotic fluid samples are being collected even from small towns like Bijnor and its adjacent villages in UP and taken for sex determination tests to centres in big towns or cities in an extremely streamlined way. The use of other technologies like ultrasound, chronic villi, biopsy, and now the newer sex preselection techniques show how medical technologies can be grossly misused in the absence social or medical controls.

While there is clearly a case against the legitimacy and ethical nature of such tests, in the absence of clear guidelines from the Indian Medical Council or the Health Ministry, and a lack of their proper monitoring, they continue to become increasingly popular, encouraging more and more female foeticide. They also lead to corruption, opening up yet another chance to make a fast buck.

When we failed to put effective controls even on drugs known for the last several decades, what will happen when newer technologies with hazards unknown or untold are dished out to an ignorant, uninformed medical community and public — as will be the case with the invasion of the 'biotechnological advances'? Who will monitor, who will provide unbiased information? Today, the post-operative complication rate of most of the sterilisation camps held is not known because there is no follow-up on them. This is when FP is a national priority. When the extent of emerging antibiotic resistance, even the basic isolation of the organisms involved in major epidemics and the extent of their spread is not easily known, then which body will monitor the negative as well as the positive impact of these technologies — no matter how scientific they may appear in controlled laboratory conditions?

If the health and consumer groups are beginning to get increasingly concerned, it is because of the secrecy that shrouds some of the recent policy decisions regarding, for instance, the Vaccine Action Programme and the Indo-French vaccine deal. This secrecy is very alarming, especially in view of the attempts by technologically advanced countries to pressurise India to change its patent laws. Veiled and unveiled threats of trade sanctions, like the ones made against Brazil, are being communicated. The US had actually stopped importing Brazil's coffee, for its failure to change its patent laws. The very fact that matters related to intellectual property

rights are being discussed in GATT, a forum for international trade matters, is warning enough for countries that aspire to be technologically self-reliant and pose a threat because of their potential for capturing some of the world's pharmaceutical market. It is in such matters that UN bodies come in to protect the already exploited. Doling out of medical care packages can never compensate for the continued socio-economic exploitation.

The Lentin Commission report which followed the needless death of 14 patients in JJ Hospital in 1988 clearly showed that it was industrial glycerol (diethylene glycol) instead of medicinal glycerol which was sold by the manufacturers. This was in violation of the tender committee specification. The glycerol had been cleared with a fake quality assurance certificate from a private drug test laboratory known to have given fraudulent results on four previous occasions in Maharashtra, a state with apparently the most stringent drug control machinery in the country. Even this historical judgement of Justice Lentin has not been acted upon. This only goes to show that it is extremely unlikely that policy decisions taken in the interest of the people will be implemented if they are not in favour of powerful vested interests.

It has been publicly stated that there is heavy pressure to change our fairly progressive Patent Act of 1970. If this succeeds, it will have serious implications not only in the field of pharmaceuticals but for things like food and seeds as well. It will also lead to increasing outside dependency, all in the hope of obtaining the swinging carrot of technological advancement, no matter how appropriate or inappropriate.

Few understand the serious implications of the recent policy changes that are being made. Major policy decisions are taken without so much as a proper discussion, debate or dialogue. The signing of the Pepsico deal and the new Seed Policy are examples. When it is already our practice to import foodgrains when drought and flood create havoc in the country, and will continue to be so in the future, putting aside thousands of hectares to cultivate potatoes (for the production of potato chips) and other cash crops will only create outside food dependency which we know has been used as a major political tool worldwide.

The fact that it involves the best fertile land of Punjab, the granary of India where agricultural trends are set, is ignored. The situation is not unlike that in Africa when, on the one hand, people were dying of starvation during famine, record exports of certain cash crops were taking place on the other. We will be exporting potato chips, vegetables and fruits which apparently are 'being wasted'.

Food is fundamental to health and while there are several ways and means of earning foreign exchange, compromising on the food front is dangerous. We know that our FCI godowns hold a lot of 'surplus

grain', while a large percentage of our people go to bed hungry, and starvation deaths and chronic starvation are not uncommon.

If food processing is being offered as a solution to the prevention of wastage, as is being alleged, then streamlining the public distribution system would probably have been a better alternative. Instead of trying to obtain foreign exchange through the sale of essential items like food, serious attempts should have been made to ensure that the poor have the purchasing power to buy food. Health services have no meaning when the availability of necessary food and adequate and safe water is not ensured. One wonders what contribution health authorities make when such policies are formulated.

It is in this context that the debt situation of the country has to be viewed with deep concern — since it is always the poor who pay the debts, while the rich take the loans. The time to pay back our loans has come. IMF's suggestion to cut the health and education budget and do away with food subsidies for the poor could spell disaster to millions, as can be seen in several Latin American and African countries. The serious implications of this suggestion have been brought out even by the 1989 UNICEF State of the World's Children report. If any budget cuts must be made, they should not be in the areas of health and education, but in those areas where gross wastage continues to take place, and which are destructive.

Undoubtedly it will be the economic, industrial, agricultural, education, housing and other policies that will affect the health status of our people. A people oriented health policy would undoubtedly help, but if other policies are destructive a health policy, no matter how wonderful, cannot undo the harm they do to life and health.

The need for UN bodies involved in health, like WHO and UNICEF, to play a more responsible role has never been as acute as it is today. The influence yielded by the countries providing the major budget for these bodies is well known. This was made evident in the 1986 World Health Assembly when Dr Hafden Mahler, the then Director General of WHO, in his opening address referred to the pressures of WHO. He compared the world health scene to a 'swamp' and the vested interests to 'crocodiles'. It was because of this subtle arm-twisting that a strong resolution on rational drug use could not be passed, nor could a strong WHO International Code on pharmaceuticals be formulated. In fact, WHO could not screen its film 'The Pill Jungle' — on drug abuse — during the International Consultation of Experts on Rational Drug Use at Nairobi in 1985, due to pressure from the drug industry.

The fate of WHO's exceptional Drug Action Programme has become a cause for great concern with the departure of Dr Hafden Mahler and Dr Ernst Lauridson, who was in charge of DAP. The heavy expenditure on salaries, consultancy fees and facili-

ties, and the wasteful expenditure on the elitist life-styles of many of the experts appears unjustified to many people in the Third World. They feel that expenditure of some of this on the programmes themselves would have been more beneficial to the people. The goldmine of information available from WHO is too costly for the majority of the health personnel and health programmes involved in the same work. Low cost versions for wider dissemination remain a dream.

Yet, for the Third World, UN agencies like WHO and UNICEF are amongst the few international platforms left where its voices can have some meaning, as was evident in the case of the Baby Food Code. The priorities of these organisations have significant and far-reaching results. They therefore need to reflect the priorities of the people, not necessarily of those that govern or finance them.

While socially conscious individuals exist in every sphere, whether it be government, UN bodies, the medical community or even the industry, the medical establishment as a whole has been unable or is unwilling to safeguard the interests of the people. It has unfortunately propagated the devastating myth that there are medical and technological solutions to the health problems we are faced with today.

In such a situation, the steady and subtle cooption of individuals and institutions in the voluntary health sector takes on a very ominous dimension. If a crisis in health exists for those who are a part of the deprived India—it is not because our nation, its resources, its trained medical personnel and its pharmaceutical industry are not in a position to ensure a resolution of the situation. It is because the 'greed of some continues to take priority over the needs of the majority'. In the process, human rights, medical ethics, social justice and rational health care stop having any meaning.

Voices raised in concern and protest against the violation of health and human rights have never quite been appreciated. The victimisation of those who speak out is becoming an increasingly common phenomenon. Denial of information and purposeful disinformation to create confusion alternate with incentives and pressures to make people comply, that is, the 'carrot' and the 'whip' phenomenon continues. Thus, while corruption grows rampant on the one hand, the process of marginalisation of the competent and 'intellectual prostitution' of others takes place on the other. Socially conscious and effective officials are quietly shifted just prior to important decisions being made.

In such a climate it is the manipulators and the manipulated who land up deciding the fate of the millions. While the medical industrial complex and the others in the business of health are thriving, the health situation of the people is far from acceptable. When faced with this reality, all the exotic and esoteric achievements made in the medical field pale in comparison.

Coming to communication about health, outdated concepts of health education, and dull, boring and uninspiring health programmes on Doordarshan, often delivered with a lack of sensitivity and respect for the intelligence and sense of the viewers, just won't do. In contrast, aggressive marketing of negative health behaviour does influence people—for example, the slick promotion of a nutritionally poor food like 'Maggi noodles' geared specially to children who are at the stage of developing their tastes for food which will influence their food consumption pattern for the rest of their lives. Information about the nutritional value of the food concerned and information about its contents—for instance, monosodium glutamate and its negative health impact—has never been demanded and ensured. But people have a right to correct information. The growing misuse of media for aggressive sales and often unethical marketing has to be stopped.

The health, socio-economic and political reality of each region must dictate its health care policies and the nature of its health care. Blueprints of health programmes made in ivory towers usually lack both 'vision' and 'spirit' as well as the capability to motivate and mobilise people for action.

If today a new breed of health activists is emerging and if people's science movements, women's groups, legal aid groups, consumer groups and human rights groups are getting increasingly involved with health-related issues and are joining hands, if sympathisers and supporters are emerging from within the bureaucracy and industry, it is because their inner core also revolts at what is going on in the health field, as in every other field, and they too feel that something must be done and done soon. Even though it is a minority today—it exists and this is the silver lining. It is the slow yet spontaneous emergence of a people's health movement.

The blueprint for rational health care cannot emerge from the Planning Commission and the Health Ministry. If it is to work, it will have to be rooted in the genuine health needs of the people and not in the 'false wants' created by vested interests. The role of others concerned about the nation and the health of its people is to lend their eyes and ears and, when needed, give the support of the strength of their arms, their thoughts and ideas, and when the going gets really difficult, be willing to stand up with a 'functional' and 'erect' backbone.

In an era of sycophancy this is extremely difficult—but where the fight for social justice in health care is concerned, where health care as a human right is concerned, it is being fought every day in different ways in different places. The guidelines for this are not provided in the national health policy documents. They emerge in the process of a struggle for building a better, healthier, and a more humanised and just world.

Comprehensive health care

N. H. ANTIA

FOUR decades after Independence, 80 per cent of our people who live in rural India have failed to receive even a modicum of basic health care. This is not due to a lack of knowledge or awareness of the problem. When it achieved Independence, India was singularly fortunate in having one of the most farsighted documents ever produced for extending the benefits of modern medical science and technology to the entire population of a vast and varied land with limited resources and a predominantly agrarian population. The report of the Health Survey & Development Committee of 1946 (popularly known as the Bhore committee), which preceded the WHO's Alma Ata report by three decades, was adopted by the founding fathers of our nation as the blueprint for the design of the health system for independent India.

This report, though produced before Independence under British chairmanship, was based not only on the experience of medical services of pre-independence India, which in turn were based on the British health system, but also on the experience of the health system as devised and operated in the socialist state of Soviet Russia. The emphasis of this report was on providing preventive, promotive and basic curative health services to all the citizens through a countrywide network of primary health centres and subcentres manned by a large number of paramedics under the leadership and guidance of doctors. It also visualised the importance of involving the people in their own health care and

ensuring cooperation between them and the formal health system.

There is no doubt that there has been an overall improvement of the health status of the country as a whole since Independence (Table 1). Unfortunately, the picture is not as rosy as indicated when it is compared with China, which started with an even greater handicap in 1949 and was cut off from the latest developments in medical science and technology, starved of foreign aid and whose major effort was in warding off various intruders. Table 1 also demonstrates the difference between Kerala and the rest of our country.

Much worse is the danger of accepting at face value the aggregate statistics presented in a country where the upper one or two deciles of the population, who have monopolised most of the gains of development and whose statistics are approaching those of affluent countries, are clubbed with those of the majority who live in poverty. The average infant mortality rate (IMR) of 96 deaths for every 1000 who are born hence conceals the unpleasant fact that the IMR of the female infants in the poorest households in the poorest villages of the poorest states like eastern Uttar Pradesh and Bihar is nearer 400 and that 60 per cent of the children are dead before the age of five years as revealed by the study undertaken by Meera Sadgopal in the villages of Madhya Pradesh.

If statistical data were collected and presented in a disaggregated form, the stark reality of the half of

TABLE 1

Improvement in health status

	1944 India	1944 India	1986 China	1986 Kerala
Infant Mortality Rate	162.0	96.0	38.0	29.0
Birth Rate	—	32.4	19.0	22.7
Death Rate	22.4	11.1	7.0	6.7
Life Expectancy	26.7	52.0	—	68.0
Maternal Mortality	20.0	5.0	—	—

Source: Health Statistics of India, 1986, GOI, CBHI.

our population that lives below the poverty line in the 600,000 villages would be revealed. Mortality figures also fail to reveal the morbidity status of our people which remains extremely high due to diseases like tuberculosis, leprosy, worm infestation and poliomyelitis.

The disease pattern as well as the mortality and morbidity rates in western countries during the last century were similar to what exists in our country today. Yet the health status of these countries changed dramatically well before the discovery of vaccines or drugs for the prevention and control of these diseases, thus revealing that change in socio-economic conditions with the resultant improvement in nutrition, water supply, sanitation, housing and environment is the crucial factor which determines the health status of any society. China has revealed that such a change is within the scope even of agrarian countries with limited resources, provided these are distributed equitably. There is no need to wait for affluence with its much publicised 'trickle' effect, as is argued by our elite.

While the eradication of poverty, provision of universal education and gainful employment, improvement of the status of women and other social and economic changes must remain the prime focus for upgrading the health status of our people, it is not generally realised that substantial improvement can be achieved even under the prevailing unfortunate conditions because science and technology have generated a basic knowledge to combat the majority of the killing and maiming diseases — knowledge that is cheaply and

readily available to us. We have failed to utilise this for the benefit of our people; instead we spend our time futilely chasing the 'latest' high cost technology of the West.

After Independence, despite the existence of a democratic framework, the decision for determining the developmental direction of our nation has been gradually usurped from the people who fought for our freedom and appropriated by a small section of our society, the nouveau riche and the new elite. Since the medical profession has from its inception been a part and parcel of this new class, it has, in conjunction with the rest of the elite, ensured that medical services are made to serve their own ends rather than those envisaged in the Bhore and other committee reports. The major emphasis has therefore been on expensive hospital-based, urban, curative services in both the private as well as the public sector for the convenience and monetary gain of the medical profession at the cost of basic services for the rural population. This has been clearly described in the government's own National Health Policy.

Since the private sector is only interested in providing curative medicine for those who can pay for it, the task of preventive, promotive and of basic curative services for those who cannot afford the private sector has to be borne by the government. For this the attractive and rational Primary Health Care approach of the Bhore Committee has been rightly used as the model. Unfortunately, this logical system for the care of the majority of the people who live in rural India has

failed for the following major reasons.

(a) The lack of political will to look after the interests of rural India and diversion of resources to urban centres for the benefit of the elite.

(b) Erosion of social values due to the adoption of capitalist marked economy approach to development which has bypassed the villages.

(c) The medical profession, a section of the elite, has neither the training nor inclination to undertake the type of work required in the rural Primary Health or Community Health Centres. Trained only in a personalised type of curative medicine, it has failed to appreciate the importance of preventive and promotive aspects of health care. It has failed to provide leadership to the large team of paramedical workers who work under it and has no rapport with the community from which it is socially and culturally alienated and which it looks down upon.

(d) Continuous political and bureaucratic interference and lack of support at all levels has demoralised even the rest of the health team.

(e) The single-minded obsession for achieving family planning targets has alienated the PHC and its staff from the community. This has not only emasculated all other programmes and services, including the curative services which are the priority of the people, but has also failed to achieve population control.

Primary Health Care has therefore become a mockery of the original concept and the multiplication of mistakes, as evident in the proliferation of PHCs and rural hospitals, has failed to improve the unfortunate state of affairs.

It must be realised that the concept of PHC has been converted into another techno-managerial ritual and a governmental sop for the rural population. Like most programmes for the poor, it has ended up as a further tool for their subjugation and exploitation, catchy

slogans to the contrary notwithstanding. The government has converted the admirable PHC concept into a tool for achieving its main objective which is the prevention of uncontrolled population growth of the poor who, while providing votes, also pose a threat to the survival of the existing system. Having failed dismally with covert pressures during the emergency to achieve an en masse sterilisation of the poor, it is time we realised that no amount of covert pressure, whatever its garb, can be an alternative to the reversal of the present perverse economic and industrial policies which have destroyed our villages and now threaten the cities themselves.

While no one, not even the poor, is averse to regulating his family size, to enforce family planning without improving the socio-economic conditions is like putting the cart before the horse. After four decades we must realise that there are no 'quick fix' alternatives. While no one has ever been against the survival of children, provided those who survive can live a life of happiness and dignity, the sudden discovery by UNICEF of the new, 'quick fix' strategy of child survival through immunisation, smacks more of a strategy for achieving population control than a sudden love for the children of the poor.

The studies of T N Krishnan and others have shown that population control and even immunisation can be better achieved through universal education of the female, an essential part of any socio-economic change. Why then the emphasis on the immunisation programme which, like family planning, will further divert attention from other PHC programmes and services? Why not a greater emphasis on female literacy, to which we only pay lip service, and to the provision of overall, basic health care?

If the PHC concept is to succeed there will have to be a radical change in the present top-down 'delivery' approach. As stated in the ICSSR/ICMR report, this can be only achieved if the people are given the right and wherewithal to exert administrative and financial control over

their community's health service. Unlike current practice, the health personnel will have to work under and participate with them. Only thus can the vast resources of the people be mobilised for solving their own and the country's health problems and those who are paid to serve them be made accountable.

Role of voluntary organisations

The voluntary organisations considered for the purpose of this article are those private but not-for-profit organisations working in the field of social welfare with the disadvantaged sections of the population by either providing service or helping in their development. Though termed as voluntary, the majority of those who work in them are salaried individuals, but with the major difference that their motivation is to help and support those who have been left out in the 'cold' both by the government and the private sector. Though the voluntary sector is minuscule in comparison with the country's population and economy, as well as the public and private sectors, it nevertheless plays an important role as the conscience keeper of our society. It is a society which is becoming increasingly materialistic and devoid of human values and has reduced half the population to abject poverty, allowing the few who have appropriated the fruits of development to live in opulence.

Except for their common motivation to serve the disadvantaged, voluntary organisations are a very heterogeneous group with their own thinking and motives which can range from proselatisation, charity or development to political activism. By their very nature they are highly individualistic and non-conformist, zealous in guarding their autonomy and hence difficult to organise for cooperative and concerted action. Nevertheless, because of their selfless commitment they have high credibility among the people with whom they work as well as society in general.

The strength of the voluntary organisations lies not only in their motivation and credibility but also in the freedom of action they enjoy

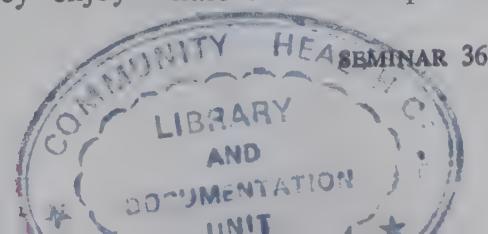
as compared with the government or even the organised private sector. They are free to choose their area as well as the type of work, can readily adapt to changing circumstances and enjoy remarkable latitude for social experimentation and research.

On the other hand, a major constraint of voluntary organisations is their inability to support themselves. They thus have to depend on external funding from international or national funding agencies, either governmental or private organisations and trusts, or through public contribution. The nature and extent of the activities of voluntary organisations are therefore to a considerable extent dictated by the source of their funds. This often results in a lack of security vis-a-vis planning large-scale, long-term activities as also in the obtaining and retention of personnel, many of whom are now highly professionalised.

Health and education are the two areas in which organised voluntary action was first initiated by the Christian missionaries during the British era. Since the chief aim was the conversion of the natives to the Christian faith, the target was naturally the poorest and the most neglected segments of society. While education had an important impact in the general development process, as can be seen in Kerala, health unfortunately still remains a predominantly charity-oriented activity. This is despite the fact that the Sarvodaya movement during the pre-independence period and the government's post-independence community development programmes (including primary health care) had a strong development and even political bias.

There are several reasons why health, unlike most other social programmes, has been looked upon in the narrow context of care of the sick and disabled and hence a charitable activity. The medical profession, which has been looked up to for leadership in the field of health, has unfortunately been almost entirely interested in medical technology for the treatment of diseases after they have occurred. This has not only provided it the halo of a 'noble profession of heal-

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ing' but has simultaneously made it a lucrative source of income while working in a convenient urban hospital or dispensary setting. In this context, the doctors have always had support from the rich and influential as well as from the politicians. There are several reasons for this. Good, curative services meet the personal needs of the affluent, while the far from satisfactory services provided for the poor salve the charitable aspect of their conscience, simultaneously producing an image of benevolence. Curative medicine is also becoming a highly profitable business and industry.

At the same time, curative medicine diverts attention from the underlining socio-economic causes of the communicable diseases which affect the poor and converts what may become a politically inflammable situation, where the poor may demand health as their right, into an apolitical, technological solution. The most important preventive and promotive aspects of medicine, which would be far cheaper and effective in improving the health of our entire nation, have always been neglected by those who control medicine and its purse. The Chadwick reforms in the middle of the last century for improving sanitation, a reform which did more for improving the health of Britain than all its medical services, was also strongly opposed by the medical profession as well as the city fathers.

Why is it then that those in the voluntary sector, who are motivated to serve the poor, have also converted health into a charitable exercise? This is because those in the medical profession who work in and guide this sector, have also been trained and oriented in the same manner as their other colleagues. Hence they, too, understand health as mainly an exercise in medical technology for the cure of disease, a view which satisfies their personal emotional needs. Needless to say, they work with great sincerity and without monetary incentive, but this does not change the health status of the community that they serve with such diligence.

Immersed in the all-absorbing and time-consuming curative services,

whether in hospitals or in the field, they believe that preventive and promotive health is best left to the government health services. Attention from these areas is also distracted because of the simultaneous heavy demand for curative help from the poor who have failed to get adequate care from the government services and cannot afford the charges of the private medical sector.

It is for such charitable, curative service, rather than preventive medicine or health education that financial support is readily available from both international as well as our own charitable organisations, and from the public. This is a further reason for the predominantly curative and charitable nature of the voluntary health organisations.

This is not to deny the importance of this aspect of the services provided by the voluntary organisations, especially in areas like leprosy and the rehabilitation of its victims. But it must be realised that this approach can ameliorate the suffering of only a fraction of all those who are in need of it. On the other hand, the community outreach approach, utilising the same manpower and financial resources, can not only serve the curative needs of a far larger population but, with concomitant health education, can mobilise the far greater resources of the community itself, which remain untapped till today.

Despite their shortcomings, the primary health centres remain the basis of the public health model. Many voluntary organisations are now showing interest in this model and this is undoubtedly a movement in the right direction. Some voluntary organisations now have community programmes affiliated to their static curative services. It is hoped that, in time, the process may be reversed so that the hospital becomes an adjunct to the community programme.

Having realised the difficulty in motivating its own personnel to operate the community based services, the government is now turning to the voluntary organisations and is even willing to hand over the

primary and community health centres to them and provide them with operating expenses. Although this scheme is attractive to many voluntary organisations whose other sources of income have been decreased by the government through tax legislation, it has problems of its own. For, while this handover may find approval among the senior policy makers, there is reservation and even antagonism at the middle and lower rungs of the government bureaucracy and service personnel who are not happy about working with voluntary organisations. This has resulted in much recrimination and frustration.

Also, there is the added danger that such handover of government resources will attract unscrupulous elements who register as voluntary organisations and besmirch the credibility of voluntarism as we know it today. Even if this scheme were to operate successfully, voluntary organisations cannot cater to more than a fraction of the public health system.

An even greater danger of the government coopting the services of voluntary organisations lies in diverting them from their far more important function, which is to serve as the eyes and ears of the people. This function is often galling to the politicians as well as to the bureaucracy. Once put in the government mould, they also lose their freedom to experiment and innovate — a crucial function which cannot be accomplished by other sectors. Instead of coopting voluntary organisations to undertake their routine functions, the government should utilise them to help evolve new methods for community involvement and participation, without which no health programme can succeed. Given their rapport with and understanding of the community, voluntary organisations are most suited for research into these aspects of health. Their findings can not only help reorient the functioning of the voluntary organisations themselves, but also aid the government in modifying their services and programmes for more effective functioning.

Several voluntary organisation experiments, like those at Mandwa,

Jamkhed and Vadu, have demonstrated the capacity of the community to undertake preventive, promotive as well as curative functions if provided the knowledge and technology in a manner acceptable to them. People have shown their ability to control even the major maiming and killer diseases like tuberculosis, leprosy, gastroenteritis, poliomyelitis and malaria, because medical science has made available remarkably simple knowledge as well as cheap, effective and safe technology for the prevention and control of these diseases.

Even our semi-literate villagers have demonstrated their ability to absorb and utilise this knowledge in a remarkably effective manner — a phenomenon not considered possible until these experiments proved otherwise. Since the majority of our prevailing health problems require low technology but high cultural affinity with the people for its delivery, it is the people themselves who will have to take the lead and demand the knowledge and support from the health services rather than the other way around, as is the case at present.

The reason why these remarkable experiments remain isolated examples is something which needs to be properly researched. There is a vested interest among the professionals of the public sector for withholding such knowledge and technology from the people: to prevent public surveillance of their functioning and make accountable what is virtually a system run for its own benefit. A system which looks upon the people only as targets for its achievement. The private sector, on the other hand, has mystified medicine to extract money from people who are in dire need during illness, with the result that extensive and dangerous malpractice is now the rule.

Public health has consequently been appropriated by both the public and the private sector, while the people themselves have been excluded from understanding and undertaking what is primarily their own function. The pharmaceutical industry, with its utter amorality,

has succeeded in obtaining government sanctions for producing and marketing a plethora of unnecessary and even dangerous drugs, so that the scarce resources of the poor are now being diverted from food to unnecessary tonics, injections and antibiotics.

In a situation where the medical profession has abandoned its role as the protector of people's health and joined the burgeoning health industry in converting illness into a means for monetary exploitation, the voluntary organisations have a major role to play in warning the public about the resulting threat to their health and welfare. It is the duty of the medical professionals in the voluntary sector to use their public credibility to undertake this task, however lonely, thankless and unpleasant it may be. They must provide the lead to stem the tide.

There are several ways in which voluntary organisations can accomplish this task. One way would be to influence their professional colleagues, for there are many professionals who watch the degeneration of morals and ethics with sadness but do not have the courage or appropriate leadership to organise and make their voice heard. The collaboration of different voluntary organisations in opposing the onslaught of the pharmaceutical industry demonstrates the growing power of right against might.

While this technical struggle must continue at the professional and legal levels, voluntary organisations can play a much larger role if they can view health not merely as medical technology but as an element in the people's struggle against exploitation and oppression. Health then becomes a part of the overall developmental process, an important cog, as it were. Withholding information and mystification of knowledge is a major tool in all forms of exploitation. Since we now know that health, which has been one of the most mystified subjects, lends itself in remarkable degree to demystification and that people can learn to look after the majority of their and their children's problems, this in itself becomes a powerful tool for helping people overcome the fears

that have been inculcated by those who wish to exploit them. If health can be demystified, they can question many of the other so-called problems that affect their life and livelihood.

Health education, as it is given today, serves little purpose except to inform the people about medical technology and asking them to help the government staff achieve their 'targets'. Alternatively, to rush to a private practitioner for any and every ailment. In actual fact, such health education is counterproductive because it mystifies health even more and can be a means of furthering exploitation. Appropriate health education can overcome this inculcated fear and encourage people to question unnecessary investigation, medication and surgery. An important aspect of such education should be to inform the people about the public services designed for their benefit which today operate in great secrecy. Only then can they demand the services meant for their welfare and bring accountability into what is a totally unaccountable system. Since neither the public nor the private sector is likely to devise and provide this information, the responsibility must rest with the voluntary sector.

Above all, the people must be made aware that the vast majority of their problems related to health and disease cannot and need not be explained away by scientific knowledge about germs. This is again a convenient technique for diverting their attention from the true cause, which is poverty and its associated ills like malnutrition, lack of potable water, and poor sanitation and environment. They must be made to realize that this is their birth right as citizens of a free country. What they need is neither welfare doles nor charity but the right to gainful employment whereby they can purchase their own food and clothing, build their own homes and educate their children. Liberated from ignorance and poverty, they can plan and supervise their health and other services to suit their needs rather than be beneficiaries of government largesse which never reaches them or be exploited by the health industry.

Role of international agencies

B. B. GAITONDE

THE World Health Organisation (WHO), founded in 1948, has actively promoted the concept that health is not just the cure of the sick or the absence of disease, but the complete physical, mental, social and spiritual well-being of an individual, ensuring a quality of life that would enable him or her to play a meaningful role in society and actively contribute to societal welfare and progress. Health is thus a fundamental right of every member of an egalitarian society and must be enshrined in the constitutions of countries committed to social justice and equality. No person should be allowed to die or suffer from disease, pestilence or disability for want of health facilities. But, alas! this is only a dream yet to be realised, even after four decades of our country's independence.

At the dawn of independence, the Mudaliar Committee proposed a rational health development plan which, had it been implemented sincerely and rigorously in its entirety, would have substantially changed the health scenario of this country. The Committee recommended the building up of a national health infrastructure with major emphasis on development of health facilities in peripheral rural areas. It gave high priority to the promotive and preventive rather than the curative aspect of health, and to the development of manpower, both professional

and auxiliary, to fit into a pattern of health development based on social needs. Our health planners have yet to achieve the goals set by the Mudaliar Committee.

International commitment to health development is enshrined in the constitution of WHO. Member states have given it a mandate for collaboration with countries in the field of health development. Such collaboration is not a one-way process with WHO assisting member countries in their health activities. It is a continuing dialogue between the international agency and the member governments for tackling difficult health situations, which have either an international perspective and a spillover or would need technical and financial resources from international organisations.

In India, several international organisations have been collaborating with the government of India since 1948, trying to seek solutions to some very difficult health problems, providing international expertise in planning, management, infrastructure development, transfer of appropriate technology, and technical expertise; manpower development through international or national training programmes, supply of sophisticated equipment and reagents, and procedures and protocols for different facets of health work. They also help in monitoring and evaluating health programmes

and financial resources which are critical in producing a catalytic effect in certain fields of health development.

The eradication of smallpox from the globe is one glorious example of what an effective and committed collaboration between member countries and WHO can achieve. It is also an example of the efficient management of a complex programme in a developing world, particularly in India and Bangladesh where smallpox was rampant and, being shrouded in superstitions, difficult to eradicate. It is also an example of the effective adoption of a simple but appropriate technology of the bifid needle and a freeze-dried vaccine successfully employed for mass vaccination. Above all it is an example of the goodwill and determination of the world community to pool together its resources — financial, human and material.

The enormous gains of this massive effort can be assessed not only on the basis of the eradication of this dreadful scourge which once took a heavy toll of human life, high morbidity and appalling disfiguration with all its social and psychological consequences, but also the total economic gains of the world community resulting from the eradication of this scourge. One has only to take into account the unprecedented rise in tourism since 1977, when the last cases of smallpox occurred in Ethiopia and Bangladesh.

The eradication of smallpox in India represents the crowning success of international efforts and is a shining example of dedication and zeal of a large number of health workers and scientists, both national and international (WHO), who worked in this programme for over 10 years. Today the world is free of the smallpox virus, but WHO continues to be vigilant. Every single case of suspected pox reported by anyone from any part of the world is investigated rigorously. Fortunately, all the alarms have so far proved to be false.

Malaria has been a priority health problem in India. At one point in time almost 60 per cent of India's

health budget was spent on this disease. One million cases of malaria were reported annually with about 100,000 deaths. Loss of manhours of work accounted for billions of rupees. The government of India, in close collaboration with WHO, started a massive programme of malaria eradication. This programme was designed, planned and implemented by Indian nationals with technical advice and inputs from WHO. By 1967, the incidence of malaria had come down drastically. There were no deaths reported and morbidity due to malaria was estimated to be about 1000 cases a year. However, something went wrong and there was a resurgence of the disease with about 1000 deaths and 100,000 cases of morbidity in 1968. Several factors were responsible — some technical and some manmade. Technically, it was not anticipated that the malaria vector all over the world would become resistant to the insecticide DDT. Parasites in some areas had also started becoming resistant to chloroquine which is a cheap, effective and relatively safe anti-malarial drug. National resources for malaria in India have dwindled, seriously jeopardising the management of the programme.

In collaboration with WHO, the government of India sought an international monitoring mission, seeking to learn from the failure of the National Malaria Eradication Programme. New strategies of malaria control have since been evolved. Large quantities of premaquinine have been supplied through WHO for the interruption of transmission. Since there is an unprecedented threat of widespread dissemination of resistant strains of falciparum malaria — a form which is highly malignant and responsible for mortality — WHO has organised a programme for the surveillance and monitoring of falciparum malaria in India's border states of Bangladesh, Burma and Nepal. A team of experts from these countries meet regularly to assess, analyse and suggest remedial measures for the control of falciparum malaria. WHO has also transferred technology for *in vitro* testing of parasite resistance to chloroquine.

Based on the studies promoted by WHO, it has become evident that

resistant falciparum is widespread in the eastern states of India, Orissa and in some pockets of Maharashtra and Gujarat. Malaria continues to dominate the health scene in India and other developing countries in Asia. Mosquitoes and parasites both seem to evade human ingenuity in controlling their sinister design. A massive international effort in the form of development of new strategies, research, management and, above all, a national commitment, including community involvement, would be required to control or eradicate this disease.

Tuberculosis also continues to be a major health problem in India despite the heavy inputs during the last few successive plan periods for its prevention and control. WHO, Rockefeller Foundation and other international and bilateral agencies have also provided substantial technical and financial inputs to support the national TB control programme. The Tuberculosis Research Institute in Madras, in collaboration with WHO and other international agencies, has made a substantial contribution in the development of strategies for tuberculosis control.

The research contribution of great global significance is the ambulatory rather than the domiciliary treatment regimen of chemotherapy for control of tuberculosis. This has resulted in substantial reduction in the cost of management of this disease. New chemotherapeutic regimens developed in collaboration with WHO and given field trials in India have contributed to the development of cost-effective treatment of active cases and interruption of the transmission chain.

More recent trials of the BCG vaccine, conducted jointly by ICMR and WHO, have raised doubts about the efficacy of BCG in preventing adult tuberculosis. The Tuberculosis Institute in Bangalore, established in collaboration with the Rockefeller Foundation, has been providing technical and managerial support to the national programme for the control of tuberculosis. Dr Mahler, who was the WHO Director-General for 15 years, served as a field staffer and worked for over ten years in India in the WHO collaborative programme

for tuberculosis prior to his taking over as the Director-General of the organisation in Geneva. His rich experience of field work in India has no doubt contributed to his excellent global perspective on health problems.

Inspite of all these efforts the incidence of tuberculosis has not been reduced significantly — we still have some 15 million cases of active tuberculosis in India. The regimen of multi-drug therapy recommended by WHO has now been introduced in the national programme. The major problem is of early diagnosis, case holding and uninterrupted supply of chemotherapeutic agents. DANIDA has provided substantial inputs for the programme in M.P. and Andhra Pradesh, for improvement in its management and its proper implementation.

Half the number of the world's leprosy cases are to be found in India. The need for controlling leprosy was highlighted through the personal efforts of the father of our nation, Mahatma Gandhi. Leprosy control is a complex, socio-economic, political, psychological and medical problem. WHO and several other international agencies such as the Sasakewa Foundation and the German Leprosy Mission have been active for over three decades in India in the field of leprosy. The national programme for leprosy control with its SET strategies based on the multi-drug regime recommended by WHO has no doubt made an impact.

The international agencies have provided very heavy inputs in initiating and supporting research, training and service institutes as in Agra and other parts of India. Through its tropical diseases research programme (TDR), WHO has provided funding and technical inputs for epidemiological and basic research, field research in the evaluation of the new armidillo derived leprosy vaccine in collaboration with ICMR, technical inputs to the Institute of Immunology, New Delhi and the Bose Institute in Calcutta through UNDP funded projects for research and development of diagnostic kits, manpower training — particularly in advanced biotechnology, including gene transfer —

splicing and genetic engineering in this field.

However, the eradication of leprosy in India does not seem to be on the cards in the foreseeable future. But it is possible to control the disease, interrupt transmission and eliminate cases with deformity through a massive health education programme for removing the stigma of leprosy, early diagnosis, rigorous treatment with multi-drug therapy and effective case holding. WHO and other international agencies are supplying large quantities of drugs such as clofazimine and ritamycin for the leprosy eradication programme.

The need of the hour is effective coordination and determined efforts based on the primary health care approach. Dr Antia has already shown in Maharashtra how community participation can be an effective strategy in our endeavour to control and prevent this disease. Although a leprosy vaccine is on the horizon as a result of both national and international efforts, it would take at least 10 to 15 years to establish its efficacy.

Technological advances in biomedical sciences have taken a quantum jump during the last three decades. Revolution in the field of diagnostic techniques, particularly in imaging techniques utilising ultrasound scanners, and magnetic resonance, has no doubt sharpened diagnostic skills. Sophisticated laboratory diagnostic kits and equipment, use of rapid techniques in the diagnosis of bacterial and viral diseases and the use of ELISA or DNA probes have also increased the chances of precise diagnosis. Advances in medical therapy have provided several alternatives for treating a disease. Research in hormone therapy, mental diseases and cardiovascular diseases has resulted in the development of effective remedies. Antibiotic and chemotherapeutic agents have revolutionised the treatment of diseases with bacterial and viral origins.

Irrespective of all these advances, the global health scene, particularly that in the developing countries, is rather depressing. In India,

infant and child mortality of 100 per 1000 births and live births and 12 per 1000 respectively are unacceptably high. Our average morbidity rates are three times higher than those in the developed countries. On an average, a child suffers three episodes of diarrhoea annually, each episode pushing it back into becoming underdeveloped and malnourished. Disorders related to iodine deficiency are rampant. Fifty per cent of neonatal deaths in some states are caused by preventable diseases. Maternal mortality is very high and acute respiratory diseases account for high morbidity and mortality in young children. The incidence of malnutrition, inspite of all the national programmes, is exceedingly high and nine million people are blind due to causes which can be eliminated.

Thus, despite all the technical advances, the health of the community is still poor and the benefits of health development have not yet reached the people who need them most. Health services in India have developed without taking into account the health needs of vast sections of the population. There is hardly any involvement of the community and the resources are definitely not equitably allocated. The allocation for rural areas, where 70 per cent of the Indian population live, is only 30 per cent. Most diseases are air-borne, vector-borne and water-borne and can be prevented or treated by simple technological interventions.

The World Bank and WHO convened global conference in Alma Ata, where 160 nations committed themselves to achieve for their people Health for All (HFA) by the year 2000 AD using the primary health care approach. And Health for All has not just remained a slogan. WHO has actively promoted HFA in all member countries, obtaining political commitment at the highest level. India, which is party to the Alma Ata declaration, has formulated in collaboration with WHO both short and long-term strategies to achieve HFA for its people. Primary health care is not 'second class' health care meant only for the poor people in rural areas. In fact, it is a health care system for

the people and by the people at their very doorstep. It emphasises the promotive and preventive aspects through health education, improved sanitation and water supply, improved maternal and child health, treatment of endemic diseases and provision of essential drugs when needed.

At the policy level it aims at the allocation of financial and human resources on the basis of community need, demanding the involvement of the community at every stage of health activity including planning at microlevel, implementation, generation of resources, and monitoring and evaluation of the health programmes. Since the district level health facility is the hub of the wheel, WHO prepared a plan of action to help develop its capabilities for management, technical competence and monitoring programmes. With substantial UNDP funding, WHO is now conducting pilot projects in four districts of Orissa and Bihar, which will serve as a model for extension to other parts of the country. It has catalysed a health movement in India aimed at producing HFA leaders from the grassroots level, who could lead this movement to achieve the objective of HFA by the year 2000 AD.

It would be absurd to think that by HFA it is meant that by the turn of the century nobody will fall ill. What the movement aims at is ensuring that every citizen of India would have access to the health facility at an acceptable level of health care and at affordable cost. Every single child born shall have a reasonable chance of survival to adulthood, with a quality of life that will enable him or her to contribute actively to the welfare of the society. This is not just a utopian dream; given the will, the efforts and resources through international co-operation, its achievement is as feasible as the eradication of smallpox.

A major deficiency of health programmes in India is the absence of proper information on health developments and an almost total lack of epidemiological services. Although there are institutions like the NICD, NIV, Haffkine, the King Institute and the School of Tropical Medicines

that undertake epidemiological and some sentinel surveillance from time to time, there is no coordinated programme of epidemiological surveillance, particularly at the state level. Epidemics usually go unnoticed till they assume serious proportions, when several agencies join together in a firefighting manner. There is hardly any training programme in epidemiology.

The government of India, WHO and USAID have together launched a programme to develop and strengthen epidemiological and laboratory services at the state level, making NICD the focal institute. The aim is to strengthen the technical capabilities of the NICD and assist the states, on a pilot project basis, to strengthen their disease surveillance through the development of epidemiological programmes. When I was the director of Haffkine Institute, I had attempted a networking of national microbiological institutes in India. It is hoped that a network of such institutes will be developed and each institute be given the responsibility for communicable disease surveillance in different zones in India.

Epidemiological surveillance needs efficient and comprehensive laboratory support. The public health laboratories in India are in a deplorable state. While teaching and research institutions have some centres of excellence, public health and diagnostic laboratories in provincial, district or rural hospitals are not adequately developed. These laboratories have been neglected and do not provide any rational support either for disease surveillance or diagnosis. The methodology in most laboratories is antiquated. They have hardly any equipment and whatever is there is not maintained and therefore out of order.

Technology is not updated and the staff is often untrained and insufficient. There is almost no quality control in laboratory work. Reagents and chemicals are not available in adequate quantities. There is no technical supervision and the laboratories are not linked with any teaching institutions. Private

laboratories are not licensed or controlled, with the result that there is widespread commercialisation, lack of quality control and therefore unreliable results of laboratory investigation.

I had repeatedly brought this state of affairs to the notice of successive Director-Generals of Health, government of India, urging them to develop and strengthen the national plan for the development of health laboratory services. We cannot afford to continue with a lopsided development of the health infrastructure if our aim is to build a comprehensive health system. WHO and USAID have provided substantial technical inputs for the development of laboratory infrastructure, introduction of appropriate technology in laboratory work — including rapid techniques in the diagnosis of bacterial and viral diseases — establishment of quality control and quality assessment programmes in clinical chemistry, haematology and bacteriology and much-needed modern techniques in laboratory management. Besides, WHO has assisted the government of India in manpower training programmes, particularly in advanced technology.

Molecular biology and bioengineering have burgeoned into the new frontier areas of research and development, making an impact on diagnostic, prophylactic and therapeutic medicine. The new DNA probes, when put into the hands of the properly trained workers, would be specific and sensitive diagnostic tools for bacterial, parasite and viral disease. Hybridoma technology for the production of monoclonal antibodies to identify specific antigens for use as vaccines and their genetic coding into vectors such as viruses or bacteria, open up new vistas of research and development in the production of vaccines. International agencies like WHO, UNDP and UNIDO are in close collaboration with the Ministry of Health, Science and Technology and Biotechnology in attempting to introduce these advanced technologies in the research institutes in India.

Thus the National Institute of Immunology, New Delhi, and the

Bose Institute and Institute of Experimental Medicine in Calcutta have received substantial technical inputs from these organisations. Several scientists from these institutes are being trained abroad in advanced centres of bioengineering research and several top international scientists are acting as consultants to the institutes through the aegis of these international organisations. UNIDO has assisted and coordinated an effort to establish an International Institute of Research in Bioengineering in Delhi and Trieste in Italy, which is expected to launch problem-oriented bioengineering research in the fields of agriculture and health.

Six hundred million people in Asia die young because of preventable diseases. The World Health Assembly has provided a massive technical input to the developing countries for the prevention of six of these diseases through an Expanded Programme on Immunisation (EPI). This programme has now been expanded into universal child immunisation and both UNICEF and WHO have provided technical and financial inputs for the software and hardware required in this important programme. Another major input has been in the fields of planning, monitoring and implementation, supply of cold chain equipment, training of managerial and technical manpower and supply of vaccines. During 1986-1987, WHO provided more than 650,000 US dollars for EPI in India. There are also inputs being provided through UNICEF and other bilateral agencies.

In the new thrust on prevention, control and eradication of polio from India before the end of this century, massive international efforts are required in planning, implementation and monitoring. WHO, UNICEF and the Rockefeller Foundation are actively involved in assisting developing countries in their determined efforts to eradicate this disease which leaves 200,000 people crippled every year in India and more than 1000 per year in Bombay alone. Given the massive national and international inputs in this programme, coupled with political will and determination, there is every possibility that this crippling

disease can at least be substantially controlled if not eradicated by the turn of this century.

This brings us to the important problem of national self-reliance in the production of vaccines required for EPI and the prevention of other diseases of public health importance. Rapid advances have already been made in the fields of immunology and immuno-prophylaxis. Bacterial vaccines have been produced in India ever since the close of the last century. In 1988, the Haffkine Institute produced a plague vaccine for the first time in the world and gave it an extensive clinical trial in India, which ultimately paved the way for the control and eradication of this deadly disease. Dr Semple at Central Research Institute, Kasauli, prepared a phenol inactivated vaccine to be used against rabies. Haffkine has been a pioneer in the preparation of cholera, typhoid and plague vaccines, as well as antisera against envenomation due to snakebites.

In recent times there has been substantial improvement in the technologies for vaccine production. Advances in immunology have also resulted in the production of newer and better bacterial and viral vaccines. The employment of fermentation technology and the utilisation of the microcarrier system for tissue cultures have resulted in the large-scale production of bacterial and viral vaccines which are more effective, safe and could be made available at economic prices. The new anti-rabies vaccine prepared in a vero cell culture, or the oral polio vaccine prepared through the microcarrier tissue culture system, or the genetically engineered vaccine against the hepatitis B virus in tissue culture, and the acellular vaccine against whooping cough are some examples of the new developments. Other vaccines, such as the antimalarial, antileprosy and anti-AIDS vaccines, are also on the cards and are likely to be available for the health programme in the next five to ten years.

Both WHO and UNICEF have assisted India in developing and strengthening its capability to produce conventional vaccines by fermentation technology. The produc-

tion of the oral polio vaccine was initiated first at the Pasteur Institute, Coonoor, and thereafter at the Haffkine Institute, Bombay, through WHO collaboration. Polio seed virus was provided and technology for the production of the polio vaccine in primary kidney cell culture was transferred. WHO also assisted in establishing and strengthening quality national control facilities at NICD, Delhi, and CRI, Kasauli. However, inspite of these efforts and international collaboration, large quantities of oral polio vaccine are, unfortunately, still being imported.

This low level of production is not due to any substantial technical deficiency, but has mainly been the result of failure, and a lack of political support. Neither the ministry of health nor the new ministry of biotechnology is interested in providing technical back-up or encouragement to Indian scientists either at Haffkine or Coonoor. They seem to be more enthusiastic about borrowing technology from abroad than encouraging our own scientists to strengthen and utilise the existing technology. The reasons behind this craze for 'foreign technology' are best known only to them. Neither China nor Mexico, both of which produce large quantities of polio vaccine, have borrowed foreign technology.

WHO has introduced vero cell technology at the Pasteur Institute, Coonoor, for the production of a new anti-rabies vaccine for human and veterinary use. The Institute has done exceedingly good work in close collaboration with the Institute of Science, Bangalore. Rather than globe-trotting in search of technology for these vaccines, such efforts should be encouraged by the authorities. I learn that the scientists at Pasteur Institute are also involved in developing a technology to microcarrier system. I know that there are some excellent young scientists at Coonoor and the Haffkine Institute. What is required are some measures to strengthen their concerted efforts to produce new vaccines. International agencies like WHO could do this by assisting in the identification, transfer and adaptation of appropriate technologies, and by monitoring and evaluating performance.

AIDS has threatened the very existence of mankind. Just as the possibility of destruction through nuclear warfare has been challenging scientists and politicians all over the world, AIDS has posed an unprecedented challenge to health administrators and planners, health personnel, scientists, sociologists and the world community. It is projected that by the end of 1990, there will be 10 million persons infected with the AIDS virus in the USA alone, and the US Health Department will really have to stretch itself treating over 100,000 AIDS patients.

In India, the few reported cases of AIDS are only the tip of the iceberg. Whatever we may say about our lifestyle or puritanical way of life, AIDS is likely to become one of the biggest challenges in years to come. No other disease, other than syphilis in the past, has taxed the health resources of a country as has AIDS. There is as yet no effective treatment for it; and a vaccine would probably take about five to seven years to be used in a field situation and may not be cost-effective.

The main plank of our strategy for the prevention and control of AIDS, at least for the present, would be to provide health education to health personnel and the community, make available condoms free of cost at every street corner in vulnerable areas, and improve our blood transfusion services. WHO has taken a global initiative and has collaborated with India in working out national strategies for the prevention and control of the AIDS virus infection and their effective implementation.

Our blood transfusion services need immediate attention. Barring one or two, the transfusion centres in India do not follow the guidelines provided by WHO. Blood donors are not routinely tested for the absence of AIDS or hepatitis infection, and where such tests are done, there is no quality control and validation. The accuracy of the test results is usually suspect. WHO has provided guidelines not only for the import of blood products but for the control of locally manu-

factured ones as well. These guidelines, if implemented, would eliminate or at least minimise the risk of contracting AIDS infection. Inspite of the reported contamination of the blood products prepared by local manufacturers, the government of India has not taken any effective steps to enforce WHO guidelines in this important area.

India is at present said to be in the epidemiological pattern three of AIDS. However, there is every indication that it will soon slip into pattern two, which implies widespread dissemination of infection through bisexual transmission. International collaboration is therefore essential for the planning, implementation and monitoring of the national programme for AIDS control, as well as for the rapid dissemination of health information and education, active surveillance of the infection and acquiring and establishing up-to-date technology for laboratory diagnosis. It is also essential that we improve our blood banking service and put an immediate stop to commercialisation of human blood, establishing facilities for the production of kits for laboratory diagnosis. We will also need to step up research to obtain new drugs, both synthetic and from traditional sources (like Ayurveda) to stimulate immune systems and the development of vaccines.

AIDS has amply proved that diseases do not remain confined just to geographical or political boundaries. An epidemic, occurring in any part of the world, can well have a global impact. With rapidly changing technologies for the control of diseases and health development, it is important for countries to actively collaborate with each other. In India, whose health development has lagged far behind many other developing countries even in South East Asia, what we need is firm political commitment, and the allocation of substantial resources and appropriate strategies for health development. There is every likelihood that this, together with active international collaboration, would positively alter the dismal health scenario of the country in a not too distant future.

The numbers game

ASHISH BOSE

COMMENTING on India's family planning efforts is indeed a difficult task, perhaps more difficult than commenting on India's planning efforts, keeping in mind the five-year plans. Planning is a complex process, rendered more complicated by the great diversity of India. In the ultimate analysis, it is also a political process.

Right from the first five-year plan (1951-56), family planning was

envisioned as a part of the total process of economic and social planning, and in particular, as a part of the health programme. Can one therefore consider it in isolation? Can one single out the department of family welfare for the failure of India's birth rate to respond to the family planning programme?

How does one evaluate our family welfare programme? By the impressive figures of targets and achieve-

ments reported by the department of family welfare or by the dismal figures thrown out by the Sample Registration System year after year, by the Office of the Registrar General under the Ministry of Home Affairs? Or should one turn to the Ministry of Education to explain the shocking figures of illiteracy and school-going population revealed by the 1981 census? (India has the world's largest population of illiterates).

If the adoption of the small family norm is a part of the total 'package' (to use Rajiv Gandhi's favourite term) of our developmental efforts and an item on the modernisation agenda of the Indian economy and society, should one not look at the record of our anti-poverty programmes? The theory of demographic transition does not say that poor, illiterate, rural people will bring about a sharp decline in the birth rate. To say all this is not to bail out the Ministry of Health and Family Welfare for India's ineffective family welfare programme, but to point out the conceptual problems involved in any evaluation of the programme itself.

Even before independence, Jawaharlal Nehru and Subhash Chandra Bose had advocated birth control (the expression common in those days) in order to raise the people's standard of living. After independence, Nehru, as the first chairman of the Planning Commission, clearly recognised that rapid population growth was an obstacle to economic growth and incorporated state advocacy of family planning in the five-year plans. In fact, India claims to be the first government in the world to have adopted a state-sponsored population control policy. Unfortunately, however, even after the near completion of seven five-year plans, we are nowhere near our goal of population stabilisation. The early lead we got was lost half way and today, several Third World countries are more successful than us on the family planning front. India's family planning programme has yet to take off.

It was RA Gopalaswami, the 1951 Census Commissioner who, in his report on the census, clearly

brought out the danger of uncontrolled population growth facing India, and pleaded for the curtailment of 'improvident maternity'. But it was not until the first results of the 1961 census were out, which revealed a much higher rate of growth of population than anticipated by the Planning Commission, that we woke up to the threat to economic development from the accelerating rate of population growth arising out of a diminishing death rate and a high birth rate showing very few signs of decline. The 1951 census actuary had estimated that during the 1941-51 decade, the birth rate was as high as 40 per thousand and the death rate 27 per thousand. In fact, some demographers put the birth rate figure even higher.

The Planning Commission had to revise the assumptions regarding the anticipated growth rate of population. This upward revision continued after every decennial census results were known. The 1971 census gave another jolt to the Planning Commission and the 1981 census gave a high voltage shock to the whole country. From the very first plan onwards, we have been chasing population growth rate targets without achieving any of them in any plan period. It is a sad story of the vanishing horizon.

The international donor agencies in the 1960s had rather simplistic notions about the relationship between population growth and economic growth. The popular view was that foreign aid was being eaten up by population growth: hence the supreme need for population control. Another simplistic, in fact, reactionary view was that success in death control would only aggravate the population problem. Therefore, a direct attack on the birth rate must be made, regardless of the level of the death rate or the infant mortality rate.

At the sophisticated level it was argued that it would be demographic fatalism to wait for India's demographic transition to take place on the lines of such transition in the West. The argument ran as follows: 'Modern contraceptive

technology can do the trick. One need not wait for the lengthy process of demographic transition. Time is running out. One has to run to be in the same place (*Alice in Wonderland*, etcetera). The thing to do is to distribute contraceptives from helicopters, install a big clock which will announce the growth of population with a bang every few minutes, run family planning camps, sterilise thousands of people in a matter of days, give monetary incentives to people ..'.

It is unfortunate that under such international pressure, a new Department of Family Planning was carved out in the Ministry of Health and was renamed the Ministry of Health and Family Planning in 1968. There was an enormous increase in the funds allocated for family planning. There was also a vast increase in the 'health' infrastructure through an expanded network of primary health centres and sub-centres, the focus being on family planning. The emphasis shifted from health to family planning. *This was a distinct departure from the Nehru line reflected in the earlier five-year plans.*

Again, under the influence of powerful international birth control lobbies, the entire family planning strategy was reworked in terms of targets (for each method of birth control) set by the Department of Family Planning (with the help of statisticians). These were distributed to the states after a perfunctory discussion at the National Development Council (where the chief ministers are present). The states, in turn, distributed the targets to the districts which then distributed them to blocks, primary health centres and sub-centres. Thus India's family planning programme became vertical with a vengeance. The central government met one hundred per cent of the funds allocated to family planning. Why, it was argued, should not the centre, therefore, direct, supervise and monitor the programme? Of course, it was understood that health was a state subject and at the grassroots level the programme was to be run by the states.

Then came the Emergency in 1975 and family planning was

proudly announced as an item on Sanjay Gandhi's Four-Point Programme though it was not an item in Prime Minister Indira Gandhi's Twenty-Point Programme. The Emergency tightened and expanded the family planning targets and 'over-zealous bureaucrats' (to use Mrs Indira Gandhi's expression) vied with each other to fulfil them, often having to resort to body-snatching. Very soon it led to the fall of the government. We are not aware of any other government in the world which was voted out of power on the issue of family planning.

When Mrs Gandhi returned to power in 1984, she tried to restore the credibility of the family planning programme by declaring that her government was totally in favour of a voluntary programme. In fact, she wanted a people's movement to propagate family planning. The Janata Party, which was briefly in power, had changed the nomenclature from *family planning* to *family welfare*. Mrs Gandhi paid increasing attention to MCH (maternal and child health) as also to the ICDS (integrated child development services) programmes. The Department of Family Welfare, however, continued to work in isolation inspite of frequent exhortations in national and international seminars and conferences about the need for an integration of health and family planning.

At the grassroots level, however, the focus was still on family planning targets which the lower level bureaucracy, medical as well as non-medical, was pressurised to fulfil. Health work began to be increasingly neglected. The only thing that mattered was the family planning target. The credibility of the health programme was thus further eroded. It was family planning at the cost of health and not a part of health as visualised by Nehru.

To escape from punishment, the bureaucratic machinery took recourse to a safety valve, namely, over-reporting the family planning performance statistics (also called 'fudging' or 'cooking' of data). To

make matters worse, cash awards to states were instituted to encourage competition between states in family planning performance. The highest award was Rs 2.5 crores. This led to further over-reporting of family planning performance data (perhaps the easiest thing in the world is to over-report the data on users of IUCD, condoms and oral pills).

When Rajiv Gandhi came to power in 1985, he himself monitored on the computer different sectors of the Indian economy and noted the stalling of the birth rate around 33 per thousand for the last 10 years or so. He made it clear in no uncertain terms that he did not regard the performance on the family planning front as satisfactory and called for a restructuring of the family welfare programme. He also emphasised a positive programme of human resource development and set up a new umbrella Ministry of Human Resource Development.

The international lobbies, meanwhile, took a somersault and suddenly came out with child survival and safe motherhood strategies. It was argued that unless infant and child mortality rates go down drastically, people will not take to family planning. Our illiterate rural masses always knew this, but for our international agencies this was a new discovery. On Indira Gandhi's birthday on 19 November, 1985, the Prime Minister launched a new programme called the Universal Immunisation Programme (UIP) with its accompanying slogan, 'Immunisation for All by 1990'. This was in addition to the earlier slogan (as per the Alma Ata Declaration) of 'Health for All by 2000'.

But unfortunately, in spite of this emphasis on maternal and child health, the focus at the grassroots level continued to be family planning targets. The stranglehold of family planning targets is so firm that our bureaucracy at the centre is convinced that if the targets are removed, the family planning programme will collapse.

Anyone conversant with the field situation will testify that for thou-

sands of family welfare workers and millions of acceptors and potential acceptors of one or the other method of family planning, the family welfare programme is still perceived as the family planning programme which, in effect, is the same as the sterilisation programme. A look at the government statistics will indicate that the sterilisation programme is basically a female sterilisation programme.

This programme generally uses the laparoscopic method of sterilisation, a method which has crashed from its initial popularity because of the lack of adequately trained doctors and an almost complete disregard of medical ethics by the medical profession which pays no heed to prior check-up and follow-up of the acceptors. This is not to find fault with this high-tech method of sterilisation but to expose the weaknesses of the proposition popular in some influential quarters that high-tech plus modern managerial techniques will deliver the goods in India. Our contention is that *surgical methods cannot usher in social transformation*.

The major weaknesses of India's family planning programme are:

(i) Under the influence of powerful international birth control lobbies and foreign donor agencies, the programme has revolved around contraceptive technology, starting from large-scale vasectomy through the camp approach, then shifting to IUCD (the loop method) and then to the laparoscopic method, the latest being the oral pill. In the absence of proper medical counselling, adequate training and supervision of the medical staff and effective management of the health delivery service at the grassroots level, all these methods have failed to satisfy the people.

(ii) Again, under misguided foreign advice, the family planning programme has been increasingly commercialised by introducing the so-called compensation for loss of wages which led to the introduction of other incentives in cash and kind. There is incentive money for the doctor, for the so-called motivator and also for the

acceptor. The incentive money is the highest for sterilisation, a nominal sum for the IUCD and none for the conventional contraceptives (condom) and the oral pills. Apart from corrupting the system, this fosters a bias in favour of *terminal* methods over the non-terminal methods of spacing.

It must have been obvious that young couples would not ordinarily accept terminal methods, but because money was involved, there was a vested interest in adopting them. Our rural masses knew better and they outwitted the bureaucracy by going in for the terminal method only *after* they completed their family building (that is, after they had five or six children and ensured that there were at least two living sons) and that, too, because they would get some money. In fact, this was not a family planning programme but a *one-shot, mini anti-poverty programme*. It is a fallacy to think that under Indian conditions, money power can change reproductive behaviour.

(iii) Given the requirement of foreign donor agencies to closely monitor the family planning programme, it was thought that the only way to do so was to set targets and keep track of the performance figures. Our planners and policy-makers thus became prisoners of these targets. The so-called method mix of family planning and target setting, sitting in the Ministry of Health and Family Welfare at the centre, is the most ridiculous thing that one can think of in a free society where the bureaucrats have no control whatever over the reproductive lives of millions of couples throughout this vast country.

It is paradoxical that the *family* is nowhere in the picture as far as the family welfare programme is concerned. There is no attention given to the family as an institution, and to the role of family solidarity in fighting physical, social, economic and emotional insecurity. And yet life revolves round the family in India, perhaps much more than in any developed country of the world.

(iv) Finally, India's family planning programme has seen increasing

bureaucratisation and centralisation to facilitate the management of the huge funds allocated to it under each successive five-year plan. The people are nowhere in the picture. They do not count. The only concern is with targets. The number game is being played with impunity.

There are limits to what our bureaucracy, for that matter, any bureaucracy can do. There are limits to what high-tech can do. We believe that India's ineffective family planning programme cannot be explained only in terms of its operational inefficiency with regard to its implementation. One has to look deeper into societal forces and one such powerful force is what we call 'demographic fundamentalism'.

The desire for sons is so deep-rooted, so pervasive and so compelling in Indian society that it cannot be described merely as son-preference or son-complex as it often is in demographic literature. The desire for sons is a product of our history and culture. It tends to cut across religions, castes, rural-urban residence and socio-economic strata. It is pathological. It has a finality about it. However, demographic fundamentalism should not be confused with religious fundamentalism that opposes family planning *per se*.

A complicating factor with profound social implications which has recently emerged off the scene is amniocentesis or the pre-determination of the child's sex. This technology gives the power to the practitioner of demographic fundamentalism to act decisively and put an end to the female foetus. Curiously enough, high-tech is helping to fan the flames of demographic fundamentalism.

Amniocentesis must thus be debated from the moral, medical, legal, economic and social angles. In fact, a national debate is called for. For there is every possibility that in the years to come, demographic fundamentalism as reflected in the son-complex will bring new distortions into our social system, though it may help the practice of the small family norm. But as of now, the situation is as follows:

Our rural masses have their own minimum needs programme in terms of the number of sons and *the cut-off point is two living sons*. The government of India's perception of a small family is in terms of *two* children which could mean one son and one daughter or two sons or two daughters. But for our rural masses, children mean two living sons. In order to have two living sons one must have at least three sons (in real life, children cannot be had in decimal points) and in the process of acquiring three sons one may also get three daughters. This will mean six children per family.

Since the government of India's family planning programme relies so heavily on sterilisation, a terminal method, the rural masses have no use for the programme until their minimum requirement in terms of two sons is fulfilled. In short, implicit in the reproductive behaviour of our rural masses is the concept of *child survival*, which is now the most fashionable theme on the international scene. The rural masses are, however, not content with mere child survival. It is a question of *family survival* and the survival of two sons is an essential element in the strategy of family survival. Since one cannot order only two sons, family building continues till two sons survive. All this means an average family size of five or six children, as just explained.

It would be unfair if our concept of demographic fundamentalism is used to denigrate our rural masses. Given the complete lack of social security for our poor (no unemployment insurance, old age pension, sickness benefits, etcetera) in the rural areas (especially for the landless who are the poorest), it is *family solidarity* which matters. Perhaps things would not have been so bad if our anti-poverty programmes had worked well and if our literacy programmes were effective; in short, if in the absence of state social security, rapid economic growth and higher literacy and educational levels had acted as catalysts in the process of demographic modernisation.

Kerala stands out as the only shining example of demographic modernisation. And if the birth rate in Kerala is what is claimed, credit must go to the larger package of social investment on health and education rather than to the sterilisation target-oriented family planning programme. If Punjab is showing signs of catching up with Kerala in regard to demographic modernisation, credit must go to the Punjabi farmers who are sending their children and grandchildren to school, marrying their daughters late, and recognising the virtues of the small family norm. At the back of it is the green revolution, and the higher income and employment levels (Punjab has the highest per capita income among all the states).

Interestingly, in the neighbouring state of Haryana (which has the second highest per capita income), compared to Punjab, the literacy levels are lower, the age at marriage lower, and the status of women is perhaps the lowest in India. In a recent study conducted by the Population Research Centre of the Institute of Economic Growth, based on 2,286 couples who had accepted the sterilisation method of family planning in three of the best performing (in terms of the couple protection rate) districts of Haryana, it was found that only 20 per cent of the acceptors cared for the two-child norm. Of these, 14.2 per cent had two living sons, 5.7 per cent one son and one daughter and 0.1 per cent had no sons and two daughters. It follows, therefore, that even if the couple protection rate is as high as 60 per cent, only 12 per cent (that is, 20 per cent of 60 per cent) would have adopted the small family norm as prescribed by the government of India. This is the impact of demographic fundamentalism and gives a clue to the stalling of our birth rate.

In a recent survey conducted by the Operations Research Group (ORG), Baroda, it was found that in Uttar Pradesh, 84 per cent of the couples desired two or more sons. In Andhra Pradesh, the figure was much lower at 51 per cent.

Family planning cannot succeed in India unless we are able to over-

come the *son line* indicated by the number of couples who have fewer than two living sons and are waiting to complete the quota of two sons. The preference for sons is strong almost all over India, especially in the states of Bihar, Madhya Pradesh, Rajasthan and Uttar Pradesh (our acronym is BIMARU states) which account for 42 per cent of India's rural population. It is the weakest in states like Kerala where, among other factors, the matrilineal system does make a difference.

Space does not permit detailed statistical data, but a recent analysis based on data collected through large-scale sample surveys in these four states indicates that in terms of family planning roughly 58 per cent of the couples are below the son line and will therefore resist family planning. In other words, only 42 per cent belong to the responsive group. It is our contention, therefore, that no matter how efficiently our family planning programme is run or how modern our contraceptive technology is, there are limits to what a programme centred around contraceptive technology can do. At most, it can get 42 per cent in the net and that is the figure we are nearing, if the statistics for CPR of the Department of Family Welfare are to be believed. In short, our *Family Planning Programme has reached a dead end*.

What should we do then? Throw up our hands in despair and wait for the results of the 1991 census to give the programme a fatal shock? Certainly not. Prime Minister Rajiv Gandhi, soon after he came to power, clearly recognised that the family planning programme had failed to deliver the goods and asked for a new strategy. But, as of today, neither the Ministry of Health and Family Welfare nor the Planning Commission has come up with anything. We are still maintaining the *status quo*. Wanting more of the same thing. Increasing the financial allocations for family planning. Creating more bureaucratic positions. *Where are the people in this number game?*

Without being cynical, let us briefly describe the family plan-

ning scene with clinical objectivity. The central government thinks that if it does not meet the entire cost of the centrally-financed family welfare programme, the states will do nothing and the programme will collapse. The Planning Commission thinks that the states are reluctant to put their own money into the programme (for example, hundreds of positions of male multi-purpose workers are vacant in some states because the money has to be found by the states while the position of female multi-purpose workers have been filled because the money comes from the central government) and endorse the view that the programme will collapse if it is left to the states.

The states, in turn, feel that the centre is being too dictatorial and trying to run the programme from New Delhi. It is also alleged that the central government itself is responsible for messing up schemes like the Community Health Worker Scheme (subsequently renamed as the Community Health Volunteer Scheme and currently called the Village Health Guide Scheme).

At the district level, blame is put on the PHC doctors and the ANMs (auxiliary nurse midwife) at the sub-centres for neglecting their work. But if one talks to the doctors at the PHCs, they tell you, 'We are trained as doctors and not as social workers. We cannot go with folded hands to the villagers in order to get family planning cases. What health work can we do? We are judged only by the number of sterilisation cases'.

Then we move on to the sub-centres. The ANM will tell you, 'Has anybody cared to look into our problems? What about our physical security? We are constantly bullied and pressurised by all ... panchayat members, youth leaders, doctors, bureaucrats...we have dozens of registers to fill up. We never get the registers on time and then we are accused of not doing our work. As if all this is not enough, we have to fulfil the family planning targets set for us by our bosses and if these are not fulfilled, we will be transferred to the worst places. What can

we do if the people do not want to undergo sterilisation? We have nothing to offer to the people. The revenue officials offer land, loans and other favours if the people agree to get sterilised. But what can we offer to the people?

Finally, talk to the people themselves. They complain that there are not enough medicines at the PHCs. the doctors and nurses are not available, they are treated rudely, nobody cares once the sterilisation operation is over, they do not know what to do if there are post-operative complications, the failure rate of the laparoscopic method is high...the *sarkar* is not bothered about the plight of the people.' Ask them what they want. Quick will come the answer, 'We want a hospital, good doctors, free medicines... Don't you get all these in the cities?'

It is a fallacy to think that demographers can suggest a way out. Most of our demographers are 'decimal-point demographers' who cannot go beyond their statistics, let alone go beyond family planning to devise new strategies. Without an adequate backup of fieldwork, these demographers can only offer statistical solutions like NRR of one, which, is totally incomprehensible to our politicians, planners and policy-makers. The issue is not NRR equals one. For our villagers, who cannot count beyond 20, is it not the height of absurdity to tell them the population of India in 2001 will be over 1000 million, and therefore, there is great danger ahead? Our villagers cannot tell if 100 crores is a small figure or a large figure. But what they do know is that if they have no sons, they are doomed and the government of India will not come to their rescue.

The foreign expert tells us, 'In such a situation, the thing to do is to offer a bond of Rs 50,000 to all couples who stop at two daughters.' It is unfortunate that in the West, where the institutions of marriage and family are on the decline, the only thought is still about monetary solutions. This will not work in India. While working in a remote Rajasthani village, we asked

the villagers, groups of men and women, why they wanted two sons. Quick came the report, 'Why do you want two eyes? Is that a question to ask?'

Before we conclude, we would like to place before the readers the following prescription which space does permit us to spell out in detail: (i) Disband the Department of Family Welfare and *merge it with* Health. Go back to the Nehru line of health encompassing family planning. Only such a shock treatment will improve the credibility of the health programme which has been eroded over the years. The target and case approach has ruined the credibility of the health programme. We have done much better on the health front than on the family planning front, judging by the recent figures for the death rate and the increase in the expectation of life. Family planning will not succeed unless we do good health work.

(ii) De-bureaucratise the family welfare programme and hand over the entire motivational work to the non-governmental sector, in particular to women's organisations. If there are not enough women's organisations doing constructive work in rural areas, then new organisations should be created instead of expanding the present bureaucratic structures. Only then will it become a people's movement, not for family planning alone but for a better deal for women. The women are the worst victims of early marriage, dowry, neglect and unwanted pregnancies. The women's organisations should thus be given the fullest backing to start a social reform movement which will fight the evils of dowry, bride burning, early marriage, unwanted pregnancies, the son complex and the general neglect of women.

(iii) Introduce a policy of positive discrimination in favour of women, to fight demographic fundamentalism. If necessary, amend the Constitution of India. Say that women will be given preference in every field and specially in regard to employment. In short, make women assets and not liabilities. This is human resource development.

Mother and child

INDRA BHARGAVA

MOTHERS and children form a very large proportion of the population and, as a group, are very vulnerable to disease. Care of mothers and children has far-reaching benefits, which may extend even to the next generation. Their care can thus be regarded as the most effective health intervention. Our national health policy has accorded very high priority to health programmes related to mother and child care, as is evident by the large number of goals to be achieved in this field by 1990 and 2000.

For too long now our health services have been operating in a very narrow area. They need an intersectoral approach to specifically overcome the differentials in relation to rural areas, survival of the child, its gender education and economic trends. And looking beyond health, the use of modern management methods must also be considered.

The problem of the health status of mothers and children has to be viewed in a broad perspective which goes beyond its medical dimension to include its social, cultural and economic aspects. This approach is reinforced by the National Policy for Children (1975) and the National Educational Policy (1986) which put considerable emphasis on child health and development with special attention to the prenatal period of development and ensuring optimum physical, mental, emotional and social development.

The female of our species enjoys a considerable degree of biological superiority in that she has more genetic material, an advanced maturation and a delayed aging process, being less prone to degenerative diseases and enjoying greater longevity. This biological advantage is

lost somewhere in the social set-up and health care system, possibly in the provision of maternal care during pregnancy and childbirth.

As far as health is concerned, a mother is always a mother, not only during pregnancy and lactation but otherwise too, whether nursing a child or pursuing a vocation. Health programmes must therefore aim at providing suitable care in the period between pregnancies as well. The basic concept is to render all possible help to her during maturation, preparation for pregnancy and childbirth, support during pregnancy and childbirth and care between pregnancies, including spacing of pregnancies and, if needed, sterilisation after raising a small family.

Since India is a very vast and diverse country in terms of states, languages religions, cultural beliefs, traditions and climate, it is essential that we adopt an area specific, district level approach to health. Though a large population is often considered a liability and an impediment in the development process, with proper planning and implementation this liability can be converted into an asset. This can be done by ensuring better child care and services through improved training of personnel, planning, management and supervision of the programmes and teamwork by all concerned.

It is essential that Maternal and Child Health (MCH) activities are related to its objectives. If this is ensured, the irrelevant and unproductive components of the activities can be pruned and the relevant ones stressed, leading to a considerable economy of time, effort and resources. What follows is a prototype listing of the bare minimum of objectives and activities:

Objectives**Activities****A. Mother**

1. Avoid early pregnancy
2. Spacing of children
3. Care during pregnancy
4. Maintain health between pregnancies

B. Newborn (upto 28 days)

1. Care during delivery
2. Timely care of the sick
3. Early breastfeeding

C. Infant (upto 1 year)

1. Breastfeeding and weaning
2. Control of diarrhoea
3. Control of infectious diseases

D. Children (over 1 year)

1. Control of infections
2. Optimum growth

Family planning
MCH services
Health services

Newborn care
Health education

Health education
Diarrhoea management
Immunisation

Immunisation
Nutrition

MCH activities operate after the basic spadework has been done in the Minimum Needs Programme which provides the infrastructure and trains different categories of workers. MCH can utilise this infrastructure and the manpower by providing the materials and the relevant knowhow. It is essential, therefore, to establish an effective, stable and productive linkage with other sectors in the health and other ministries.

Government activities in relation to the MCH programmes can be divided into two categories: programme and non-programme activities. Programmes can again be classified into target oriented and non-target oriented activities. The target oriented activities include immunisation and prophylaxis schemes while the non-target ones include basic MCH services, control of diarrhoea and infant feeding. Non-programme activities include basic childbirth services, group educational activities, inservice training and management courses in immunisation, and training of trainers for different programmes.

The targets of MCH programmes are rather simple. Immunisation programmes aim at achieving, in a phased manner, 85 per cent coverage of infants and 100 per cent coverage of pregnant women by 1990. The coverage of older children is also expected to reach 85 per cent by 1990. Prophylaxis schemes against blindness due to

Vitamin A deficiency and against nutritional anaemia aim at a 50 per cent level of initial coverage of those at risk, with a gradual increase to 100 per cent.

Current MCH activities are a mix of target-bound immunisation and prophylaxis schemes. The targets are not necessarily determined by the health needs of the community but are often allotted on other considerations. The programme for Oral Rehydration Therapy (ORT) has yet to produce a perceptible impact and a lot more attention needs to be paid to basic MCH services for childbirth and the newborn. This is the crux of the problem. The target-bound programmes seem to be oriented towards performance in a quantitative manner, often with scant attention given to the quality of the services.

Family planning and MCH are the two arms of family welfare. Integration of these two arms can be more effective on account of its flexibility of operations, being oriented towards the recipient and having a greater involvement of the community and can result in a greater acceptance of family planning by giving it the required credibility and improving its cost-effectiveness. The advantages of a small-family norm and proper spacing of children in relation to survival, reduction of morbidity, proper development and the

improved health status of a child are obvious and have far-reaching effects on productivity and the quality of life of the nation as a whole. This has been conceptually agreed to, but is hardly brought into action, with the result that the concern for MCH has been able to advance from an area of neglect to an area of indifference.

Primary Health Centres (PHCs) provide appropriate promotive, preventive, curative and rehabilitative services and emergency care to meet the main health needs of the community with special attention to vulnerable groups and is responsive to the needs and capabilities of the people. This care has to be culturally acceptable, technologically appropriate and manageable, and consist of selected interventions implemented in combinations to meet local needs. It requires development, adaptation and application of appropriate health technology which can result in a functionally efficient and supportive health care system.

Accessibility is the main factor in relation to primary health care. It can be defined as the continuing and organised supply of care that is geographically, financially, culturally and functionally within easy reach of the community. Geographical accessibility implies that the distance, travel time and means of transport are acceptable to the people. Financial accessibility means that the services can be afforded by the community irrespective of the modes of payment. Cultural accessibility implies that the technological and managerial methods used are in keeping with the cultural patterns. Functional accessibility ensures that the right kind of care is available on a continuing basis to those who need it, whenever they need it, and that it is provided by the health team in an appropriate manner.

The PHC system has now been in operation for more than a decade. Many people feel that the infrastructure and the system used has not been fully successful in achieving the objectives originally aimed at. The salient shortcomings of the primary health care system are poor attention to its functional aspects and a lack of monitoring and

supervision and, therefore, proper evaluation. The result is that these services have not made any perceptible impact. While the concept of primary health care as perceived in our policies is a sound one, its implementation is half-hearted and the resources allotted to it are insufficient. Its not surprising, therefore, that the results are not what they should have been. Immediate attention towards ensuring the quality and monitoring its impact is thus vital for the success of the programme.

Improvements in our health system, we have no doubt, led to an increase in the life span and improvement in the health status of the people. However, the mortality of mothers, newborns and infants has not shown a corresponding decline and continues at unacceptably high levels.

In a family, the mother has a pivotal role to play. In her absence the family breaks down, quite often in an irreparable manner. It is therefore reasonable that the problems of mortality of mothers and infants should be tackled together. The health status of women has far-reaching effects on their productivity. It is necessary to reduce the workload of women in terms of daily household chores, and to ensure the availability of drinking water and fuel in the vicinity of their dwelling. It is also essential to improve the employment conditions of women in relation to pregnancy, provide adequate nutrition to expectant and lactating mothers and offer nursing mothers the possibility of home employment.

Where children are concerned, the problem is essentially of survival and if they survive, immunity from infections there is possibility of optimum growth. Adequate care of children can lead to better chances of survival, improved health status and optimum growth. With further care of adolescents one can expect a better working force, a healthier nation, more productivity and a better quality of life. Prevention of disability, morbidity, debility and mortality must be the prime concern of any health programme. Prevention of childhood

handicaps can have far-reaching economic benefits. In industry, the ill-health of children is a frequent cause of absenteeism with consequent loss of wages.

Infant mortality is the most sensitive indicator of mother and child health care in a country. At the time of independence, infant mortality in India was very high. Then a minor decline was observed till 1980. With intensive efforts in the delivery of comprehensive mother and child health care, infant mortality has declined even more during the last five years. But the current mortality level (1985) of 95 per 1000 live births as the national average is still an unacceptably high one.

Infant mortality is the result of a complex interaction between a series of medical and social factors. The main medical causes for infant mortality as shown by the survey conducted by the Registrar General of India in 1979 are: prematurity, respiratory infections, factors related to childbirth, diarrhoea, fever, malnutrition and tetanus in the newborn. The predisposing factors for each of these causes show a wide range of diversity. The appropriate remedial measures are thus correspondingly different.

Besides the direct medical causes for high infant mortality, socio-economic imbalances in the distribution of income, low purchasing powers, malnutrition, paucity of essential food commodities, inadequate calories, proteins and micronutrients in the average diet, lack of knowledge about balanced nutrition and hygiene, lack of safe drinking water and poor sanitation are also contributory factors.

Nearly 60 per cent of all infant mortality occurs in the first 28 days or the perinatal period, and is largely a result of factors not very difficult to avoid. Therefore, in our strategy for lowering infant mortality in a significant manner, priority should be based on the magnitude of contribution of each factor and the efficacy of corresponding remedial measures. Hence the priorities in the strategy must comprise provision of appropriate perinatal care,

including immunisation against tetanus which can reduce infant mortality by at least 50 per cent or so.

Generally speaking, during immunisation a person forms antibodies against a particular disease, without going through an active disease process, since the antigens are introduced into the body in a risk-free manner. These antigens may be dead organisms, live attenuated viruses or some part of the micro-organisms. After immunisation, a child shows an immune response, leading to a reduction in its vulnerability to the concerned disease, as a result of which the incidence of the disease in the community is lowered and mortality is reduced. This leads to optimal growth of the children which, in turn, will improve their health status.

In order to produce the desired effect, immunisation services need to be supported by proper attitudes towards health and life-styles, personal and community hygiene, good environment and balanced diet. As a result of this programme, the incidence of target diseases has shown a decline, many health functionaries have been trained, children have been immunised in an age-specific, target-bound manner and more information is available about the prevalence of these diseases. Immunisation is focused on 85 per cent coverage of infants and 100 per cent coverage of pregnant women. Total coverage during the last year has crossed 15 million infants and over 13 million pregnant women.

The immunisation programme now follows one of two strategies: the regular EPI and the accelerated UIP one. While UIP aims to cover all eligibles, EPI aims to cover only the feasible ones. UIP is distributed over some selected districts whereas EPI is spread all over the country. Thus, while the operational unit in UIP is a district, in EPI it is a state. The eligible groups in UIP are infants and pregnant women, while EPI includes older children as well. Immunisation against measles is compulsory in UIP but in EPI it is limited to a few areas. Supplies, training, reporting and surveillance are emphasised a lot in

Minimum Perinatal Care

<i>Level</i>	<i>For</i>	<i>Where</i>	<i>By whom</i>	<i>Components</i>
I	75%	Home, sub-centre, PHC	TBA, MPW (F)	Basic Care
II	20%	Small hospitals	Doctors	Fetal Monitoring
III	5%	Large hospitals	Specialists	Sophisticated Care

UIP, while they are rather modest in EPI. Thus although their approaches are different, both strategies are directed towards the same purpose, namely, the universal coverage of pregnant women and infants all over the country by 1990.

The target diseases for immunisation are not major contributors to the unacceptably high level of infant mortality. While immunisation of infants and children will tackle the mortality due to target diseases, its main role will be to reduce the ensuing morbidity and prevent disability due to poliomyelitis. Since almost 60 per cent of infant mortality occurs during the perinatal period, provision of appropriate perinatal care and immunisation of pregnant women against tetanus should be the interventions of choice for a significant reduction in infant mortality.

A comprehensive MCH programme provides care to all mothers and children irrespective of the pregnancy status and age of the children. However, given the constraint of resources, it is not possible for the national programmes to cover every person at all ages in the MCH programme. Priority has to be given to causes which have a high incidence and are preventable in nature, and to certain age groups. It is obvious that the highest priority should be given to services for childbirth and care of the newborn — what we refer to as perinatal care.

Minimum perinatal care consists of three tiers. The first level provides basic medical care through first contact workers (TBAs and MPW[F]) at home, the sub-centre or the PHC. Level two provides care at the small hospitals through doctors and requires a set-up that includes facilities for fetal monitoring. Level three provides sophisticated medical care to the newborns and mothers at large hospitals through specialists.

The essential components of minimum perinatal care are:

1. *For the mother:*
 - a. Antenatal care
 - * Early detection of pregnancy
 - * T.T. immunisation
 - * Identifying high risks
 - * Regular check-ups
 - * Nutritional supplements
 - b. For childbirth
 - * To ensure a safe and aseptic delivery
 - c. Postnatal care
 - * Early breastfeeding
 - * Regular check-ups
 - * Advice on family planning
2. *For the newborn*
 - a. Care at birth
 - * Establish cardio-respiratory effort
 - * Care of the cord and the eyes
 - * Temperature control
 - * Physical examination of high risk cases
 - b. Neonatal care
 - * Early breastfeeding
 - * Monitoring physical activities and reassuring the mother

Since mother and child have to be taken as one unit, minimum perinatal care has to receive the pride of place in any MCH service. Other components can be provided subsequently. The strategy proposed is based on the three-tier perinatal care with a risk approach to identify factors and outcomes, according them relevant priorities and selecting suitable interventions with a blend of appropriate technology to identify techniques in a need-based manner, evaluating innovations and incorporating the useful ones in the activity so as to form an operational model of minimum perinatal care. The main task that remains is to disseminate information and knowledge about the service.

It is rather disheartening to see paediatricians and obstetricians adopt

an indifferent attitude towards perinatal care. The support of professionals to this vital component of MCH care has to be mobilised, so that plans can be made and implemented. In the past about 340 district hospitals were given pediatric equipment. Of these, about a 100 also got equipment for the care of newborns, as did nearly 27 medical colleges. Unfortunately, most of them have not produced the desired results since a working arrangement between pediatrics and obstetrics could not be achieved.

Facilities for childbirth in rural areas are provided through a birth attendant who may or may not be trained. A beginning has been made in providing a trained dai in every village. Almost 90 per cent of the villages have been covered. However, a number of questions crop up in this regard, answers to which will help us determine whether we really have succeeded in providing measures for safe and aseptic childbirth. These questions are:

1. How good are our childbirth services?
2. How good are our birth attendants?
3. Are you satisfied with their training?
4. If not, what are the lacunae?
5. How much do the birth attendants cover and refer?
6. How well do they cover and refer?
7. What is done when something goes wrong?
8. How can this intervention be reinforced?

A review of health statistics for the decade beginning 1976 to 1984 reveals that different mortality rates in relation to young children have shown only a marginal decline in this period. The infant mortality rate has fallen from 129 to 97, the neonatal mortality rate from 77 to 65.8, the perinatal mortality rate from 66.8 to 53.6, and the postneonatal mortality rate has declined from 52 to 38. On the other hand, per capita income has gone up from Rs 1075 to Rs 2355, the number of sub-centres has increased from 47,172 to 83,546, primary health centres from 7540 to 11,848 and community health centres from 217 to 675.

Immunisation coverage with TT for pregnant women has risen from 2.14 million to 9.3 million, and DPT coverage from 4 million to 12.4 million. Coverage under prophylaxis against nutritional anaemia has risen from 8 million to nearly 18 million. But this improvement does not reflect any appreciable dent in neonatal or perinatal mortality and has benefited mainly postneonatal mortality. This implies that neonatal mortality calls for measures over and beyond those covered by the present MCH activities, that it is not directly related to the per capita income, and that the health infrastructure created so far must engage in tackling this problem in a more specific manner.

Voluntary agencies have an extremely important role to play in the provision of MCH services to the community. The professional associations can *a.* reinforce training through a task-oriented approach leading to a need-based curriculum and strategy, and train the trainers; *b.* disseminate knowledge at all levels and evolve appropriate health education for the public; *c.* make operational plans based on the recommendations, assess their impact and suggest appropriate modifications.

In close collaboration with the professionals, the government has developed the concepts and prepared guidelines for action in the vital area of perinatal care. Plans for initiating action on this aspect in the form of area specific strategy are already being implemented in certain states. Earnest effort is needed to evolve a working partnership between the government and the professionals as a means for ensuring the quality and impact of these services.

Why is maternal care so luke-warm? Are the personnel really equipped with the required skills? Are they capable of making judgements and decisions? These are some of the major questions which face people engaged in MCH care. Training in this vital branch of health care is conspicuous by the absence of a specialist degree or diploma course for medical personnel in most of the universities. The

concept of training as consisting of a task oriented approach, purposive learning, its evaluation and ultimate utilisation is hardly operative in this area. The casual attitude of medical teachers is revealed by the fact that during 1980-1984, an MCH curriculum for medical graduates was introduced in 45 of the 106 medical colleges in the country. This project had to be dropped for want of senior teachers coming forward to participate in the exercise.

The health of women and their productivity has far-reaching effects on the social and economic status of the community. It is desirable that the huge womanpower in the country is utilised for activities other than reproduction. One such activity could be generating income from health activities. This additional income will ultimately contribute towards improving the standard of living and the health status of the family.

As far as management of the programmes is concerned, considerable caution has to be exercised in attaching too much significance to data from a small project and considering the results of a study covering a limited area as being unreservedly applicable to the rest of the country. It has already been observed that small pilot projects, despite being very successful, rarely lend themselves to large-scale implementation, particularly because it is not easy to replicate the dedication and commitment of the workers in the project in other areas.

To sum up, mother and child care holds the key to the control of population and primary health care for all by the year 2000 AD, both of which are our priority commitments. Besides serving these two goals, it can also lead to a marked improvement in the health status of the nation with far-reaching socio-economic benefits. To achieve this, however, the care has to be of the desired quality. This quality can be ensured through a pragmatic and realistic approach, providing task-oriented training to all workers, and monitoring and evaluating for quality in order to obtain the impact envisaged in our national health policy.

Intellectual property rights

PARVINDER SINGH

INDIA is committed to the 'Alma Ata Declaration' to attain health for all by 2000 AD. This in itself will be an important landmark to achieve on entering the 21st century. By that time, our requirement of pharmaceutical products is likely to go up to around Rs 10,000 crores per annum (the Indian Drug Manufacturers' Association estimated it at Rs 16,000 crores), that is, over four times the availability of about Rs 2,350 crores in 1987-88. Correspondingly, the requirement of bulk drugs would also rise to Rs 3,500 crores per annum as against the production of Rs 480 crores during 1987-88. Yet in the global context, the current Indian market for pharmaceutical products is only 1.9 per cent of the world market.

The per capita annual (1985) consumption of drugs in India is US \$ 2.3, which is far lower than that of Argentina at \$ 39.6 and that of Japan and the USA which is as high as \$ 116.2 and \$ 110.5 respectively. These countries have much better living conditions; even so, they have significantly high levels of drug consumption. (In real terms, however, the gap is not that large since prices of medicines in USA are at least 10 times higher than Indian prices). Nevertheless, when we compare health care conditions in these countries with those in our country, the task which lies ahead for our government and for the pharmaceutical industry becomes a gigantic one to accomplish.

Health Sector: Status & Indicators

The health care programmes initiated and executed by the government

over the last three decades have strengthened the health care system and the well-being of the general population and have yielded tangible results, particularly in the field of communicable diseases. Measures have been initiated to improve referral services and health care services in rural areas through the Minimum Needs Programme. The life expectancy at birth in India has gone up from 39.9 years in the 1950s to 55 years in 1985; the infant mortality rate has come down from 146 per thousand lives at birth during the 1950s to 106 in 1985. Similarly, the death rate (per thousand) has come down from 27.4 in the early 1950s to 12 in 1985.

The health infrastructure has also been strengthened considerably. By 1985-86, the country had about 88,950 sub-centres, 8496 primary and subsidiary health centres, 650 community health centres and 7474 hospitals with a provision for 5,35,735 beds. The number of students who qualified for MBBS in 1985-86 had increased to 11,992 as against 1,557 in 1955-56. The number of doctors and nurses registered in 1985-86 were 2,97,228 and 1,70,880 respectively. Similarly, the pharmacists registered as per the data of the Pharmacy Council of India in 1985-86 were well over two lakhs. India is wedded to grow through a planning process and these achievements have been possible through five-year plan outlays, which were increased to Rs 6649 crores for the seventh plan (1985-1990) against the outlay of Rs 65

crores in the first plan (1955-56) for Health and Family Welfare Programmes.

In the background of these health indicators, the National Health Policy provides crucial goals for the Health and Family Welfare Programme to achieve by 2000 AD. An infant mortality rate of below 60 per thousand has to be achieved and the death rate (per thousand) is to be brought down to nine. The immunisation status for TT will have to go up to 100 per cent and that of DPT, polio, BCG, DT and typhoid to be accomplished upto 85 per cent. The arresting of leprosy and TB cases, out of those detected, are to go up to 80-90 per cent. These cherished goals have been set by India for itself and all future planning in the health sector is directed to accomplish them. Government has already evolved the following national health programmes to provide a greater thrust to the health care system:

1. National TB control programme.
2. National leprosy eradication programme.
3. National malaria eradication programme.
4. National filaria control programme.
5. Diarrhoeal diseases control programme.
6. Sexually transmitted diseases (STD) control programme.
7. National programme for control of blindness.
8. National mental health programme.
9. Guinea worm.
10. National goitre control programme.
11. Kala-azar control.
12. Expanded programme of immunisation.

It is expected that during the following two five-year plans significant achievements will be made in improving health care in the country.

force, the Indian pharmaceutical industry has achieved diversified growth which has placed it solidly on the world map. UNIDO has classified the Indian pharmaceutical industry as having acquired the characteristics of :

- * near self-sufficiency in raw materials to start production of drugs from basic stages;
- * wide-ranging therapeutic groups of drugs produced;
- * using advanced development and process research;
- * possessing an efficient distribution system;
- * levels of operation being comparable to international standards in production, technology and quality of products.

The industry has recorded substantial growth during this period, as is evident from Table 1.

TABLE 1

Year	<i>Production of Bulk Drugs</i>	<i>Production of Formulations</i>	(Rupees in crores)	
			1964-65	1975-76
1964-65	17	135		
1975-76	130	560		
1987-88	480	2350		
Growth (since 1975-76)	3.7 times	4.2 times		

The demand for pharmaceutical products has been increasing rapidly and the industry has played a commendable role in anticipating and meeting this demand. It is presently producing drugs of various therapeutic groups, that is, antibiotics, antibacterials, analgesics, antipyretics, anthelmintics, anti-TB,

TABLE 2

Capital Investment in Pharmaceutical Industry	
Year	Investment
	(Rs. crores)
1952	24
1962	56
1973	225
1977	450
1982	600
1987	850

vitamins, etcetera. Of the more than 10,000 manufacturing units currently operating in the country, 250 are in the organised sector, including multinational companies with foreign equity. It is estimated that the pharmaceutical industry's total investment has grown from a meagre Rs 24 crores in 1952 to Rs 850 crores (see Table 2).

Future Challenges before the Industry

Domestic Demand

The per capita annual consumption of drugs in our country is extremely low — less than Rs 30 (in rural areas, it is less than Rs 10) per annum—as compared to other countries. Though the per capita consumption during the last one decade has gone up threefold, we are still far behind many developing countries.

In our villages, where the health care system is extremely weak, the requirements of modern drugs needs to be higher than it is at present. There is, thus, a great challenge before the industry to ensure that drugs reach the masses in rural areas in order to achieve the goal of 'Health For All by 2000 AD'. It is anticipated that by the turn of the century, the demand for pharmaceutical products would be around Rs 10,000 crores against the current turnover level of Rs 2750 crores (estimated for 1988-89).

Export Potential

In addition to domestic need, there are vast opportunities for exporting drugs to both the developed and developing countries. The export performance of the industry during the recent past has been excellent. During the last three years, exports have risen from Rs 194 crores in 1985-86 to Rs 290 crores in 1987-88. The industry is now well poised to make a major thrust on the export front and its export performance is expected to exceed Rs 1,000 crores per annum well before the turn of the century.

The global drug market during the last one decade has grown from US \$ 43.05 billion to US \$ 94.1 billion. However, India does not contribute even two per cent of the

total market. The industry's attempt to generate large exports is now being appreciated and with the government's pragmatic policies and the industry's ability to develop cost-effective technologies, India can certainly do much better in the coming years and emerge as a potential exporter in the world markets. Already the industry has been able to make its presence felt in the developed countries. The buyers of the Indian drugs percentage-wise of total export (1987) are shown in Table 3.

TABLE 3

Exports to Developed Countries	
	%
USSR	33
USA	14
West Germany	6
France	4
UK	4
Japan	4

Performance of the Industry

Pricing of Products

A committee of the US Senate (Kefauver Committee) had commented in 1959 that 'Prices of certain drugs and antibiotics in India were amongst the highest in the world' and that, in drugs, 'India was one of the highest priced nations'. But this was before the enactment of the Patents Act in 1970. It is noteworthy that prices of drugs in India are now amongst the lowest in the world. This is borne out by the data presented in Table 4.

The price comparisons in Table 4 comprise only a few examples. In most countries which follow product patents, prices of these and other pharmaceutical products are as high if not higher. Further, in the domestic market, the price rise of pharmaceutical products has been the lowest as compared to other price-regulated products of common use in the country. This is evident from Table 5.

TABLE 4

Sl. Product No.	Indian Prices		Prlce in Other Countries		Price differential High/ Times
	Pack	Prices (Rs.)	Pack	Price (Rs)	
<i>Comparison with USA Prices</i>				<i>USA Prices</i>	
1. Alprazolam —0.25 mg Tabs	10's	3.00	100's	325.36	10.8
2. Diazepam —2 mg Tab	10's	2.18	100's	312.34	14.3
3. Ranitidine —150 mg Tabs	10.s	19.00	100's	1673.27	8.8
4. Reserpine —0.25 mg Tabs	10's	0.63	100's	98.71	15.7
<i>Comparison with UK Prices</i>				<i>UK Prices</i>	
5. Mebendazole —100 mg Tabs	6's	4.88	6's	37.92	6.8
6. Nifedipine —10 mg Caps	100's	50.00	100's	296.34	4.9
7. Ranitidine —300 mg Tabs	10's	36.00	30's	666.82	5.0
<i>Comparison with Australian Prices</i>				<i>Australian Prices</i>	
8. Atenolol —50 mg Tabs	10's	8.45	30's	90.18	3.6
9. Nifedipine —10 mg Caps	30's	13.49	100's	199.04	4.4
<i>Comparison with New Zealand Prices</i>				<i>New Zealand Prices</i>	
10. Atenolol —50mg Tabs	10's	8.45	30's	126.78	5.0
11. Nifedipine —10mg Caps	30's	13.49	100's	293.50	6.6
<i>Comparison with Switzerland Prices</i>				<i>Switzerland Prices</i>	
12. Nifedipine —20 mg Caps	10's	15.00	28's	457.92	10.9
<i>Comparison with Malaysian Price</i>				<i>Malaysian Prices</i>	
13. Propranolol —10mg Tabs	10's	1.42	1000's	799.20	5.6
14. Frusemide —40 mg Tabs	10's	1.68	250's	472.14	11.2

TABLE 5

Industry	Wholesale Price Index (Base 1970-71 = 100)	1986-87 Annual Increase
1. Coal	716	39
2. Electricity	564	29
3. Cement	469	23
4. Sugar	401	19
5. Edible Oil	379	17
6. Drugs & Medicines	203	6

The pharmaceutical industry in India has been under price control for a long time now. The impact of this control is also evident from a comparison of the All-India Consumer Price Index. (see Table 6).

TABLE 6

	All Commodities	Drugs Medicines
Base 1970-71	100	100
1980-81	270	137.5
1983-84	321.7	189.2
1986-87	377.8	203.7

Research & Development

It is therefore clear that India's pharmaceutical industry has done well in meeting the national requirements and has now begun to play an important role in foreign trade. This has been possible mainly because of the opportunities which became available to Indian scientists and to the national companies to develop process technologies for bulk drugs because of the process patent system enunciated under the Indian Patents Act, 1970.

The period of introduction of new drugs in India has been reduced to 4-5 years from the 10-15 years that it was before the Patents Act, 1970 (see Table 7).

The scientific achievements in introducing new drugs in the country are commendable. Production of about a 100 bulk drugs (Table 8) has been started in the country with cost-effective process technologies developed through indigenous efforts.

There are even newer drugs whose product patents have yet to expire in the world market. Some of these drugs are already being produced in our country whereas production of several other new drugs will also be started in the coming years by national sector companies.

However, global pressures are now being mounted to curtail the freedom presently available not only to the domestic pharmaceutical industry but also to pesticides, petrochemicals and the food industries, thereby directly affecting the opportunities for self-reliance and export performance as well as availability of products at comparatively low prices.

Intellectual Property Rights

Intellectual property in India, as elsewhere, is covered by patents, trade marks, copyrights and designs. All of these have statutory recognition and protection in India through the Patents Act of 1970; the Indian Trade & Merchandise Marks Act, 1958; the Copyright Act, 1957; and the Patents & Design

Act, 1911 (for designs). For the pharmaceutical industry, it is mainly the Patents Act which is relevant for its sustained growth.

International interest in patent laws has taken many forms. In the recent past, a more aggressive initiative has been launched by foreign interests on the Indian government to make substantial changes in our 1970 Patents Act. Earlier, there was pressure from the World Intellectual Property Organisation (WIPO) for India to join the Paris Convention. Pressures are now being mounted through the forum of GATT. Negotiations and the bilateral Science and Technology Initiative (STI) Agreement between India and the USA which, in October 1988, was extended for a further three years. The joint statement issued in regard to this agreement says that 'India and the US agree to consider the question of providing for protection and allocation on a mutually agreeable basis of any Intellectual Property Rights arising out of the STI Programme'.

The main reason for increased concern about the enforcement of industrial property rights is the tremendous imbalance in its trade which arises from the containment of its traditional export markets in Europe, Latin America and Asia. The US trade deficit in 1987 and 1988 was \$ 154 billion and \$ 137 billion, whereas Japan and West Germany had a surplus of \$ 135 billion and \$ 85 billion respectively. It is because of the all-round rise in the industrial potential of these highly developed countries and certain developing countries, that USA is bringing pressure against the third world countries, including India, to establish a monopolistic regime to reverse its trade imbalances.

The Indian Patents Act

The first Patents Act was enacted in 1856, when India was under British rule. In 1911, a comprehensive Patents & Designs Act was enunciated and this Act remained operative till it was repealed by the Patents Act of 1970. The basic reasons why government amended the old Patents Act of 1911 were:

TABLE 7

Introduction of New Drugs

	Introduced in World	Introduced in India	Gap Years
Salbutamol (Anti-asthamatic)	1973	1977	4
Mebendazole (Anthelmintic)	1974	1978	4
Rifampicin (Anti-T.B.)	1974	1980	6
Naproxen (Anti-Rheumatic)	1976	1982	6
Ranitidine (Anti-Ulcer)	1981	1985	4
Norfloxacin (Anti-Bacterial)	1984	1988	4

TABLE 8

Bulk Drugs Manufactured by National Sector Companies Based on Indigenously Developed know-how

1. Acetazolamide	33. Diphenyl Hydantoin	65. Nitrazepam
2. Allopurinol	34. Diphenhydramine	66. Nitrofurantoin
3. Amitriptyline	35. Doxycycline	67. Norethisterone
4. Amodiaquin	36. Emetine	68. Norfloxacin
5. Amoxycillin	37. Erythromycin	69. Paracetamol
6. Ampicillin	38. Ethambutol	70. Pethidine
7. Analgin	39. Ethinyl Estradiol	71. Pheniramine
8. Aspirin	40. Ftorafur	72. Piperazine
9. Atenolol	41. Folic Acid	73. Piracetam
10. Betamethasone	42. Frusemide	74. Progesterone
11. Caffeine	43. Furazolidine	75. Propranolol
12. Ca. Sennoside	44. Gentamycin	76. PVP — Iodine
13. Carbamazepine	45. Glybenclamide	77. Pyrantel Pamoate
14. Cephalexin	46. Guaiophenesin	78. Pyrazinamide
15. Chloramphenicol	47. Heparin	79. Quinidine
16. Chlordiazepoxide	48. Hydrochlorthiazide	80. Quinine
17. Chlorpropamide	49. Hydroxyprogesterone	81. Ranitidine
18. Chloroquin Phosphate	50. Hydroxyzine	82. Salbutamol
19. Cimetidine	51. Ibuprofen	83. Silver Sulphadiazine
20. Ciprofloxacin	52. Indomethacin	84. Sterbutaline
21. Cisplatin	53. Isopropylantipyrine	85. Sulphacetamide
22. Clofazimine	54. Kanamycin	86. Sulphamethoxazole
23. Clofibrate	55. Lorazepam	87. Sulphamoxole
24. Clonidine	56. Mebendazole	88. Theophylline
25. Cloxacillin	57. Metaprolal	89. Thiacetazone
26. Cyproheptadine	58. Methocarbamol	90. Tinidazole
27. Danazol	59. Methyl Dopa	91. Trimethoprim
28. Dapsone	60. Metronidazole	92. Trioxsalen
29. Dexamethasone	61. Nalidixic Acid	93. Vinblastine
30. Dextropropoxyphene	62. Niacinamide	94. Vincristine
31. Diazepam	63. Nicotinamide	95. Vitamine B-12/ Other Vitamins
32. Diloxanide Furoate	64. Nifedipine	

(a) An indepth study of the old patent system by committees headed by Justice Bakshi Tek Chand and Justice Rajagopala Ayyengar, revealed evidence about the misuse of patent protection by foreign companies to ensure protected markets for themselves;

(b) More than 90 per cent of the patents in India, registered by foreigners, were not being worked in the country;

(c) The patent system was being exploited by foreigners for monopolistic control and most of the goods were imported from abroad at extremely high prices;

(d) The law prevented the country from obtaining goods for its essential requirements from competitive sources in the

international market, since patent protection included the right of importation as well. The pre-1970 patent system thus reserved the Indian market for foreigners.

The conditions prevailing in our country at that time were similar to those in the UK during the early years of its industrial development at the beginning of this century. Commenting on the exploitation of the UK markets by foreign patentees, Sir William Holdsworth, who was speaking to the House of Lords, said:

The foreign Patentee acts as a dog in the manger, sends the patented articles to this country but does nothing to have the patented articles manufactured here. He commands the situation and so industries under our

own law are starved in the interest of the foreigners.

Sir Robert Reid was more outspoken when he spoke in the House of Lords on the subject:

Nothing can be more absurd or more outrageous than that a foreign patentee can come here and get a patent and use it, not for the purpose of encouraging industries of this country, but to prevent our people doing otherwise what they would do. To allow our laws to be used to give preference to foreign enterprises is to my mind ridiculous.

Germany provides a similar interesting example of exploitation through the patent system. In 1876, when the German industry was in its infancy, a committee was appointed to study the likely impact of

patents. Representatives of Siemens and Hoechst were the members of this committee. Their observations make interesting reading:

Today industry is developing rapidly; monopolization of inventions and abuse of patent rights will inevitably expose large segments of industry to serious injury. The Government must protect industry against these dangers These patents will not be taken out in order to protect industrial plants established or to be established in Germany; they will be taken out to monopolize production abroad. These articles will be imported into this country. Such a danger must be met.

India holds a similar view today precisely because it is concerned about its future industrial growth.

Basic Philosophy of the Indian Patents Act 1970

The basic philosophy of the Act is that patents are granted to encourage inventions and to secure that these inventions are worked on a commercial scale without undue delay. This philosophy is sought to be achieved through provisions such as:

* *Licence of Right* (general provision)

Central government may make an application after three years

for endorsement in public interest on any patent the provision of 'Licences of Right'.

* *Licences of Right* (for process patents)

Process patents registered for food, medicines, drugs and chemical substances are deemed to be available for licensing automatically after three years.

* *Compulsory Licensing*

Compulsory licences are granted after three years if reasonable requirements of public interest have not been satisfied about the availability and pricing of products.

* *Revocation of Licences*

If the patent is not worked within two years after the grant of the first compulsory licence, the patent can be revoked.

Another pragmatic provision in the Indian Patents Act limits registration to only process patents — e.g., for food, medicines or drugs, pesticides and chemical substances. Products vital for our economy such as agricultural and horticultural products, atomic energy inventions and so on, are not patentable at all. The various provisions of the Indian Patents Act have been designed in a balanced manner to achieve the objective of the working of patents by the patentee himself or through licences (under the Compulsory Licensing or Licensing of Right provisions). However, since 1973-74,

when the new Act came into force, only 33 applications for Compulsory Licensing have been filed upto 1985-86.

The Paris Convention

The need for a patent system in an industrialised country is quite different from that of a developing country. Whereas traditionally, developed countries have been advocates of a strong patent protection system establishing their monopolistic regime, the developing countries hold that the system should be designed so as to help in the development of indigenous manufacturing facilities.

The Paris Convention is an international treaty that was signed in 1883, basically to protect the interests of the industrially advanced countries. The original text of the Convention has been revised *only* six times in over a 100 years. Starting with the Brussels Conference in 1900, it ended with the adoption of a revised Act of the Paris Convention at Stockholm in 1967. An interesting feature is the increase in the number of developing countries in the membership of the Paris Convention. At the first revision in 1900, there were only three developing countries. The number rose to 14 at the fifth revision in 1958, when almost all the developed countries (26 of them) had joined. Table 9 gives the membership position at the different times of the Convention's revision.

Between 1900 and 1958, when the developed countries had an absolute majority, significant revisions of the basic provisions of the Convention tended to strengthen the position of the patentee and weaken the rights and privileges of the country granting the patent. Upto 1958, the participation of the developing countries in the shaping as well as in the operation of the international patent system remained minimal.

Current Revision — Status

At the sixth revision in 1967, the number of developing countries had risen to 43. Despite the fact that developing countries constituted a majority in 1967, the Stockholm

TABLE 9

Membership at the Time of Paris Convention

Place and year of Revision	Group of Countries — Membership of Paris Union	
	Developed countries	Developing countries
Brussels	1900	13
Washington	1911	16
The Hague	1925	22
London	1934	24
Lisbon	1958	26
Stockholm	1967	29
Geneva (Ongoing Revision)	1987	29
		60

revision did not reflect the urgent needs of these countries. It is also relevant to note that some of the largest developing countries had not joined the Convention till then. These included Afghanistan, Bangladesh, Burma, Chile, Colombia, Ethiopia, India, Malaysia, Pakistan, Peru, Thailand and Venezuela. The Soviet Union joined in 1965 and China in 1985.

Initiatives for the seventh revision of the Paris Convention were started after the Declaration of the New International Economic Order was adopted in May 1974 by the UN General Assembly. This declaration aims at correcting inequalities and redressing existing injustices between the developed and developing countries. In December 1975, the *ad hoc* Group of Governmental Experts for the Revision of the Paris Convention set up by WIPO adopted a Declaration of Objectives comprising, *inter alia*, the following aims to be achieved by the revision:

- (a) To give full recognition to the needs of countries for economic and social development and to ensure a proper balance between these needs and the rights granted by patents;
- (b) To promote the actual working of inventions in each country;
- (c) To facilitate the development of technology in developing countries and to improve the conditions for the transfer of technology under fair and reasonable terms;
- (d) To encourage inventive activity in developing countries;
- (e) To increase the potential of developing countries for judging the real value of inventions for which protection is requested, for screening and controlling licensing contracts and for improving information for local industry;
- (f) To ensure that all forms of industrial property are designed to facilitate economic development and to ensure cooperation between countries having different systems of industrial property protection.

This Declaration contains strong and specific commitments by developed countries to undertake structural adjustment to help in the economic development of developing countries. Multilateral negotiations between the developing countries and developed countries on the issues raised by the Declaration have been going on with a view to revising the Paris Convention, but due to a conflict of interests, no decisive agreements have been reached. In fact, from the latest trend of discussions in the Uruguay Round of GATT negotiations, it is clear that the developed countries are now no longer interested in pursuing the finalisation of the 1975 Declaration.

As of 1 May 1988, the Paris Convention has 98 members. It is reliably learnt that more than 30 countries out of these 98 do not have the technology to make even an aspirin tablet. The Paris Convention is thus virtually a club of unequals and it is yet to be seen how far the developed countries will oblige the Third World countries in shaping their economic policies.

Salient features of the existing Paris Convention

The countries to which the Paris Convention in its present shape applies, constitute a Union for the protection of industrial property. Nationals of all countries of the Union have the same protection as their own nationals and the same legal remedies against infringements. The salient features of the Convention are:

- (a) The Convention provides for product patents and its scope extends to industry and commerce, agriculture, extractive industries and natural products;
- (b) The Convention covers patent rights on importation, improvement and addition;
- (c) A Compulsory Licence can be applied on the ground of failure to work or for insufficient working after three years of grant. It shall, however, be refused if the patentee can justify

inaction due to legitimate reasons;

(d) Revocation proceedings may be instituted two years after the grant of Compulsory Licence. These proceedings may take any length of time;

(e) Right of Priority is extendable for 12 months in all member countries from the date of registration of a patent in any one country;

(f) Member countries have to assure effective protection against unfair competition which includes reasons contrary to honest practices; and

(g) Denunciation of membership is not possible for at least 6 years after joining the Convention.

India's Stand on the Convention

India has resisted pressure for becoming a member of the Paris Convention for obvious reasons. Legal luminaries like Justice Hidayatullah, Justice Chandrachud and Justice J C Shah have opined that if India joins the Paris Convention, it will be forced to amend its Patents Act of 1970 to fall in line with the present provisions of the Paris Convention. In this connection, it may be pointed out that the Science Advisory Council to the Prime Minister had constituted a Study Group on Patents in 1986. The Report of the Study Group was considered by the Council in May 1987 and it had recommended that nothing should be done to undermine the supremacy of the Indian Patents Act. They further stated that it was important that the country continued to derive the benefits that the Patents Act had made possible.

Various chambers of industry and commerce have been specifically requested by the government in 1988 to give their views on the question of India joining the Paris Convention. These chambers have suggested that the implications of India becoming a member of the Paris Convention must be studied in depth before taking a final decision in the matter. But, by and large,

they do not want the government to succumb to pressures.

Recently, the National Working Group on Patent Laws, which represents a cross-section of associations of scientists, consumers, journalists, legal professionals and industries deliberated on the issues relating to the Paris Convention and Indian patent laws and the inclusion of Intellectual Property Rights in the GATT negotiations at a seminar organised by them on 22 November, 1988. Eminent jurists, economists, technocrats, scientists and experts participated in large numbers and, at the end of the seminar, resolved that in its scope and purpose, the Indian Patents Act, 1970, continued to represent Indian interests and required no amendments and that government should not make any change in the law and policy relating to patents and intellectual property. They recommended that this position should be maintained at the GATT conference (at Montreal) and at other national, international and bilateral fora.

This indicates that a consensus has emerged in India that there is no particular advantage in joining the Paris Convention and, in fact, the disadvantages are widespread on every aspect of our economic growth and development. Similarly, a consensus has emerged that the existing patent laws should be preserved without any modifications. It would be in our national interest to wait and observe the culmination of ongoing negotiations about the revision of the Paris Convention on the lines of its Declaration of Objectives adopted in 1975.

Renewed Pressures for Changes in the Indian Patent Act

Demand of Foreign Interests

Renewed pressures are now being applied through the Forum of GATT negotiations, by the USA, EEC countries and Japan. The campaign is spearheaded by the US which contends that intellectual property protection in India and certain other countries is inadequate and also ineffective against infringements. They demand that patentability

should cover, without discrimination, any new industrially applicable products and processes.

They also want a 20-year period for patent life; that patents not be revoked for non-working; that where, for justified legal, technical or commercial reasons the patent is not worked but importation is authorised, the requirements of working of the patent should be treated as satisfied; and that the burden of proof on the patent-holder should be reversed and made applicable to infringers to prove that they are not guilty.

Indian Patent System — Comparison

Many of the countries who are pressuring India to make changes in its patent laws had, in the early stages of their development, either weak patent legislation or no legislation whatsoever. As against this, India can boast of always having had a patent law. The first Act relating to patent rights was passed in 1856.

It should be interesting to have a look at some details about the Process Patent System in different countries.

Germany: The German Patent Law of 1877 enacted with only Process Patents for chemical products to enable scientists to develop alternate cost-effective processes for the same product.

USA: The USA itself exploited all German patents to provide a tremendous boost to their chemical industry after World War II.

UK: The UK had process patents between 1918 and 1949. Product patents were introduced only after substantial advancement was achieved by the UK industry towards technological self-reliance.

Switzerland: In Switzerland, unexpired process patents for medical and chemical substances are still valid. The Patent Law in that country was amended to provide for product patents only in 1978.

Italy: The Royal Decree of 1940 abolished all patents for chemicals

and pharmaceutical products and processes in Italy. On joining the EEC in 1978, Italy had to provide for product patents, which became effective in 1984. Following this, the share of locally-owned firms has dropped drastically while there is no positive effect on domestic R&D and export performance.

Spain: Only process patents for drugs and chemicals are applicable. Spain has also become a member of the EEC and because of this it has been forced to introduce product patents which will be effective from 1992.

Several countries still exclude patent protection to pharmaceutical products. These are listed in the following table.

TABLE 10

	1974-75	1979-80
<i>Developing Countries</i>		
Argentina	x	x
Brazil	y	y
Chile	x	x
Colombia	x	x
Ecuador	x	y
Egypt	x	x
Ghana	x	x
India	x	x
Iran	x	x
Iraq	x	x
Korea (Republic of)	x	-x
Lebanon	x	x
Mexico	x	x@
Thailand	xx	x
Uruguay	x	x
Yugoslavia	x	x
<i>Developed Market — Economy Countries</i>		
Australia	y	y
Austria	x	x
Finland	x	x
Greece	x	x
Italy	y	a
Japan	x	a
New Zealand		
Norway	x	x
Portugal	x	x
Spain	x	x
Switzerland	x	a
<i>Socialist Countries</i>		
Czechoslovakia	c	c
German Democratic Republic	x	x

Hungary	x	x
Poland	x	x
Romania	c	c
USSR	c	c

Sources: *The Role of the Patent System in the Transfer of Technology to Developing Countries* (United Nations Publication).

Notes : x—Pharmaceutical products are excluded but process included for protection; a—Products are granted protection; y—pharmaceutical products & processes both are excluded from patentability; @—process is not patentable; c—Products excluded—only inventors certificate granted; xx—Patents introduced in Thailand in 1979.

Countries like Italy, Brazil, Spain and Portugal have made substantial advancements in the pharmaceutical field for the reason that they had no patent laws. India is currently at the threshold of its industrial development and it will be suicidal to make any change in the existing Patents Act, particularly relating to pharmaceuticals, agro-chemicals, and other chemicals.

Consequences of Changing the Indian Patents Act.

If the Process Patent System, whenever applicable, is changed to product patent; if compulsory licensing becomes weak and unenforceable; if the term of all patents gets extended to 20 years and if the concept of reversal of burden of proof is conceded, the consequences will be disastrous to the Indian economy in terms of:

(a) Our current research activity, because of the stage of development and size of our businesses, is mainly directed to applied/process research. It has been possible to develop cost-effective process technologies for about 100 bulk drugs and near self-sufficiency in their production has been achieved in the country. It has also been possible to introduce newer drugs within a much shorter span of 3-5 years as against

10-15 years under the old patent system, as stated earlier in this article. Such research work will stop completely for new drugs which will become patentable. Thus, research activity in the future will be directed only at patent-expired old products (after a lapse of 20 years).

(b) No new products would be introduced by Indian companies as is happening at present. Licensing of patented products would be a prerequisite which would be extremely difficult, if not impossible to meet.

(c) The country will become entirely dependent on imports not only for patented raw materials but also for patented finished drugs as after the changeover to the Product Patent System, the foreign patent holder would register patents and delay indigenisation of production for as long a period as possible. Further, due to the monopolistic regime that will be created, products would be available at exorbitant prices, as is happening in other countries where the Product Patent System prevails.

(d) Export activity would receive a major setback, substantially worsening the balance of payment position.

(e) Roughly, about a third of the total availability of pharmaceutical products in India are purchased by institutions — governmental, semi-governmental and aided schemes. Due to a sizeable increase in the purchase prices of medicines, the budgets of all these institutions will go up by several times. Furthermore, larger plan allocations would also be needed for all governmental health-care national programmes in the central and state sectors.

(f) Due to its impact on indigenous availability and prices of medicines, the various national health programmes would be badly affected and the realisation of 'Health For All by 2000 AD' would become an impossibility.

Thus, in the overall national interest the existing Indian patent laws have to be preserved at all costs.

Books

IMPLEMENTING HEALTH POLICY by Meera Chatterjee. Manohar, 1988.

DECONSTRUCTING policy is never an easy task. Even less is it an interesting one. It is to the credit of Dr Meera Chatterjee that she goes behind the pompous statements of intent which constitute the 1982 National Health Policy (NHP) and informs the reader in an easy and engaging style 'where we are and where we intend to go' in the field of health. Hailed as a radical departure from the conventional 'more of the same thinking' that dominated the health scene for over three decades, the NHP drew a wide range of commentary when it first came out. Whereas most of the criticism located itself firmly in the tradition which argues that an inequitous social structure dominated by an oligarchy cannot but replicate the inequalitarian thrust in society, Dr Chatterjee strikes out a different path and through a detailed examination of the constituent parts, makes the reader aware of the kind of balances which need to be struck in the making of policy.

The early chapters of the book take off somewhat slowly. The introduction of the NHP; why the focus on primary health care; on viewing health not as a welfare programme but as a means to the development of the nation as a whole; the political obstacles to primary health care — mainly that like primary education, basic health too is not a fundamental right but only an intent enshrined in the 'Directive Principles of State Policy'; the fact that 'health' being listed simultaneously in the 'Union', 'State' and 'Concurrent' categories makes for a diffusion of responsibility, etcetera — are all points which have been made before. Similarly the review of the different legislations and schemes following the Bhore Committee Report add little to our knowledge, as does the charge of elite bias in policy

making, or the fact that medical professionals and the pharmaceutical lobbies have worked towards diluting the radical intent of policy makers.

The chapters on 'The Maldistribution of Health' and 'Organisation of Health' read better, partly because they tellingly bring out that an improvement in mortality indices do not necessarily improve health conditions. Equally important is the point that though mortality rates have declined over the last 40 years, there has been a slowing down of this rate of decline which should be a cause of some concern. Further, we learn that the mortality profile is highly uneven, not just regionally, but also biased against women and children, and against the rural populace. This helps us locate the target population — women and children in rural areas as the necessary focus of health policy.

The analysis of the macro data which follows only serves to confirm that the major causes of death can be located in 'prematurity' — a malnutrition-infection syndrome resulting from poor hygiene and inadequate feeding. Of particular importance is the discussion on the differential role of general development and health specific policy measures in affecting the mortality regime. Unlike many other thinkers who argue that medical interventions have played but a marginal role in the improvement of health, Chatterjee is of the firm opinion that a well-directed, thoughtful and focused health policy, even in situations which are undesirable, can and does make a significant difference.

Further, she argues that rather than focus on the individual or the community as the unit of health care delivery, the emphasis should be on the household, more so on the women as providers and beneficiaries of health care. This has important implications for the entire strategy of locating PHCs, training of health workers, the need to eschew the over-

emphasis on family planning (particularly sterilisation), the need to integrate nutrition care with health, and so on.

It is, however, with the chapter 'Community Participation in Health Care' that the book really comes into its own. Since in the new prescriptions for national health, 'community participation' is promoted as the magic wand that will not only help in getting around the usual problems of access, other than being a 'good in itself', it is essential that we understand what it really entails. The idea of community participation owes its origins to the supposed spectacular success of China's barefoot doctor scheme. The current wisdom therefore is that 'for primary health care to be delivered where people live and work, we need to train health workers who have ready access to these places. For this care to be at a cost that the community and the country can afford, what we need is a reliance on low level and labour-intensive technologies, that will be community based, staffed by village people.'

Further, since the strategy focuses special attention on vulnerable groups and stresses preventive health strategies which can be enhanced through mass mobilisation and mass education, it also meets the approval of voluntary social action groups, who in any case have been advocating this approach as their preferred panacea to all ills.

Meera Chatterjee helps us cut through the mystique of community (which is only an idealistic construct), the notion of local felt need (one is never clear whose need is being talked about), and finally works through the processes which are needed for the community to actually acquire full control. Her first point is that rather than the poor it is actually the leaders, traditional or modern, who participate, since direct contact with the poor is often risky. From the selection of the health worker, who either thinks of him or herself as a government functionary, to deciding who will pay for the services — the normal pattern which unfolds is that even this community-based and oriented service is appropriated by a minority, and as funding subsidies decline, since the poor cannot afford to pay, they tend to get excluded.

Another associated problem is the emphasis on curative and visible health work rather than the less immediately impactable preventive work. Where the results have been more heartening, say in certain voluntary projects, the limits to expansion are rapidly reached. Overall, the community health approach experience is little different from the now discredited community development approach of the 1950s. The experiences of Cuba and China are non-transferable because we have not had the social revolution that those societies went through.

Thus given the heterogeneity of the community, health itself being a low priority, the multifarious difficulties associated with self-reliance and self-care, and the lack of professional commitment — what we

end up with is a crucial double standard: poor quality and inefficient services for the poor, 'better' services for those who can afford them. Community participation thus often becomes a mode of abstaining from responsibility for the state.

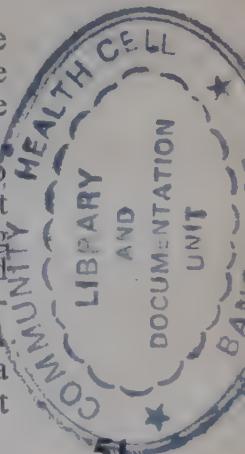
This basic argument is strengthened through an incisive analysis of the role of the private voluntary health sector, where the expected strengths of the private voluntary organisations (PVO) are offset by their many weaknesses. Thus, while as experiments the PVOs are noteworthy, as strategic players their role and contribution remains uncertain. This is brought home sharply in a detailed analysis of one low cost technology — the growth monitoring chart, universally accepted by all health agencies as a key component in child care. Just because all it requires is regular and correct weighing and entering the data on a graph sheet, it was expected that nothing could possibly go wrong.

Chatterjee has done all of us who advocate such solutions a signal service in pointing out the range of variables — from equipment, to personnel and training — that we need to be confident about, even to put one simple technology into operation. I must confess that even to a professional 'fault finder' like me, the list of what can go wrong seemed staggering. And finally, only when confronted with the resource requirement of universalising even the growth charts, can one realise why our policy pronouncements may be so out of place. To realise what appears low cost may often not be cost-effective is if nothing else an effective dampner.

Equally fascinating is the discussion on the 'spectacular' mortality figures in evidence from Kerala. The conventional wisdom is that Kerala has arrived — if mortality, infant mortality, sex ratio and life expectancy figures are anything to go by. And they are spectacular. After an illuminating discussion of what lies behind Kerala's 'success' — the early social reform, the role of the missionaries, the political movements, high literacy, the settlement pattern, low rural-urban differentials, much higher investments in social services — Chatterjee cautions us against isolating any few factors as being primarily responsible.

Not very cheering for policy planners. But more importantly, she points out that success on the mortality front is no cause for complacency, because the morbidity scenario in Kerala is grim. Further given the high levels of inequality in access to needed assets and services, particularly amongst the rural poor, with the nutritional package facing the twin pincer of demographic explosion and lowering productivity, what Kerala may experience is a sudden worsening on the health front. A fact which escapes us because by comparing Kerala with other states or countries, we often do not look intensively enough within it.

Finally, there is a discussion on the resources for health care. Here the story is one of reiteration of



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not enough money, spending on the wrong items/heads in the wrong manner and so on. Thus if the country is serious about implementing the NHP 1982, what we require is larger allocations reallocated towards non-curative heads and a vigilant monitoring of spending. Otherwise the noble aim of reduction of inequalities is likely to remain as elusive as it is now.

If there is a level at which Meera Chatterjee's extremely useful book disappoints, it is in the inadequate discussion of the politics of health and policy making, as possibly on health cultures. But then, even what she has done is valuable. One only hopes that the new Planning Commission — 'naive and romantic' as one friend has called it — takes time off to read the book before rushing off into offering the same solutions, probably garbed in more radical phraseology this time.

Harsh Sethi

IN SEARCH OF OUR BODIES: A Feminist View of Woman, Health and Reproduction in India. Shakti, Bombay 1987.

THIS collection of lucid essays is a well-argued call for change in the prevailing attitudes towards women's health and sexuality in India and, by extension, in other poor countries of the world.

The facts about women's health care are not pleasant ones. A simple table from the government of India's *Survey of Infant and Child Mortality* (1979) shows that female children suffer more frequently from every serious disease at every age than males. They die in greater numbers. They are 'breastfed for shorter periods, weaned earlier, fed less and at longer intervals. They also suffer more from severe malnutrition,' no'es an article titled *Why Do Daughters Die?*

The pretty picture continues throughout a woman's life. Public health policies and programmes mirror the overwhelming discrimination against women in India. The woman is seen either as a mother or as a means to low population growth, but never as an individual who requires specific medical services for her own survival and well-being. Birth control devices are shoved into her instead of being placed on the male priapus. She, rather than the man, is the focus of research that fiddles with hormones and operations that destroy insides. The use of tests to kill female foetuses is winked at by the government and supported by the medical establishment. 'Male hegemony exists in medicine, in policy and decision-making and in research,' writes Manisha Gupta.

This male hegemony has effectively blocked acceptance of the fact that the single most effective way to reduce infant mortality would be through improving the health of women. In a soundly

argued chapter, Dr Malini Karkal of the International Institute of Population Sciences notes that 'the neglect and undernourishment of girls sets a vicious cycle of deteriorating health of population, stagnation of death rates and continuing high mortality among infants and children. She notes that the primary cause of infant mortality is low birth-weight, which is itself decided by the nutritional and health status of the mother. Improving the health conditions of the mother should be the public health intervention of choice in a country like India.'

Sadly, the two large public health programmes advertised as being for women do no such thing. The government's much-vaunted maternal and child health (MCH) programme has been little but a front for birth control measures directed at women, writes Padma Prakash. Similarly, child health programmes pushed so effectively by the World Health Organization and the United Nations Fund for Children are based on strategies that put great strain on women but make no demands on men or on the government.

'Rigid prescription on the timing of supplementation and the pattern of breastfeeding are not helpful to mothers faced with an insanitary environment and a shortage of time, fuel and cash...international agencies vigorously promote the "breast is best" message assuming that women's work is compatible with breastfeeding and that sucking missed in the day can be made up at night. There is a great danger that this emphasis will put the burden for survival on women and divert attention from the need to improve sanitation and water supplies, income and domestic technology.' writes Vimal Balasubrahmanyam, quoting Gill Gordon in the *IDS Bulletin*.

The overt bias against women's concerns that is accepted by all types of health policy makers is not only immoral and self-defeating but also often repugnant. The concluding chapter of the book notes that 'UNICEF printed a calendar in 1983, which depicted a new stereotype of women. 12" pages of breasts in shades of white and brown, various shapes and angles, mothers holding the baby at different positions, staring soulfully into their eyes.' Gabriele Dietrich also notes that while women's 'insides and outsides' are freely depicted in family planning campaigns in India, 'the male contribution to procreation...is depicted as a giant sperm wriggling its way towards the expectant egg'.

This is a powerful and compelling critique of health policies that do nothing but keep women in an age-old servitude. Far from being polemical, the various essays are unimpeachably argued and the medical data used with care. It should be made compulsory reading for all policy makers in this country, particularly the loudmouth bigheads who feel that women should remain ill and subservient chattel.

Siddharth Dube

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Communication

FREE and fair conduct of elections to the representative bodies at different levels of the polity is *sine qua non* for the success of democracy. It is possible only when an independent organisation having statutory support is created and entrusted with the electoral responsibility. This body so created will have the onerous responsibility of conducting the elections objectively and impartially and create an absolute sense of neutrality among the different contending parties, groups and candidates.

Not only that, adequate measures against the abuse of the electoral system by vested interests and socially dominant sections have to be devised, particularly in developing societies where every conceivable method is adopted to circumvent the legal methods to capture power with the help of money and muscle power. It is indeed in view of the importance of the election system that the framers of the Indian Constitution have taken adequate care by incorporating Article 324 which established a Central Election Commission (CEC).

Preparation and periodic revision of electoral rolls, conduct of elections to the office of President, the Vice-President, both the Houses of Parliament, the legislatures in states and union territories, deciding post-poll issues such as poll expenses,

violation of election laws and so on, are some of the major functions of the Commission. At present, election matters are handled by the state executive under the overall responsibility and guidance of the CEC. The Chief Electoral Officers are designated from the senior state officials generally of the rank of the Chief Secretary.

At the cutting edge, with the help of the district bureaucracy, the district collector conducts the elections to various statutory bodies. Part-time arrangements are made and temporary promotions given to attend to the election duties. This arrangement, it was felt, would be adequate to meet the constitutional requirement but gradually the volume of work increased at a rapid pace necessitating rethinking on the working of the CEC.

II

In 1952, at the time of first general elections, the total electorate of the country was about 173 million whereas in 1989 it went upto 447 million voters. Similarly, there has been a tremendous increase in the volume of poll violence, disputes, etcetera. The political history of independent India had an important landmark in 1967, when for the first time the monolith of single-party dominance was

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broken in several states and different political parties and combination of parties came into power. Since then, the party system has undergone a total metamorphosis. With the sprouting of innumerable parties several conflicts needing the attention of the CEC have also been on the increase.

Yet another important and crucial turn in the working of the CEC was that from the fourth general elections onwards, simultaneous holding of elections to the Lok Sabha and assemblies has become a part of political history. Today, elections to the assemblies and the Lok Sabha are held at different times. This phenomenon has also greatly contributed to the increase in work-load and monitoring throughout the year. New problems such as detection of bogus voters and increase in the number of contesting candidates also demand the attention of the CEC.

Further, the recent attempts, the ill-fated 64th and 65th Amendments in particular, have envisaged a direct involvement of the CEC in the conduct of elections at regular periodicity to the five and a half lakh rural as well as a few thousand urban local bodies. This direct involvement of the CEC was suggested in view of the fact that most of the states were defaulters and were guilty of not holding elections regularly. On the other hand, the state governments adopt several despicable methods to supersede the elected bodies at the slightest pretext. Since local institutions fall under the state list, it is much easier to dispense with the elections and/or elected bodies.

Though such a change in the rural and urban local bodies was envisaged by the Congress(I) as an electoral ploy in view of the 9th general elections, the opposition parties, at that time or thereafter, did not deny the importance of such a measure. In fact, the National Front government is contemplating introducing a comprehensive bill to bring in electoral reforms. Ultimately, the direct involvement of CEC is bound to come up sooner or later. Thus it is imperative that the CEC copes with a heavy work-load, leading to a rethinking on the level of the existing organisational set-up.

The ever-increasing work-load of the electoral process, not to speak of elections to the rural and urban local institutions, made worse by attendant problems such as booth capturing, rigging and other poll offences which have become the order of the day, the present structure of the election commission, based in Delhi with a single member, is not only inadequate but may prove dysfunctional. Perhaps this might be the reason why the founding fathers of the Constitution, keeping in view the future developments, made provision in the Constitution for a multi-member election commission.

III

However, the provision was never made use of until Rajiv Gandhi decided to add two members to

the commission just before the 9th Lok Sabha elections. Critics pointed out that the government's decision to make the Election Commission a three-member body was a complete reversal of the stand taken by the Prime Minister less than a year ago. It is also alleged that this turnaround in his decision was a move to weaken the Commission and to tamper with its integrity. However, the National Front government revoked the appointments of the two additional members by terminating their services through an executive order.

In this whole process the Commission was made to be the victim of political gimmickry. Neither Congress(I) nor the National Front, it appears, has any concern for the real problems faced by the Election Commission. The problems of the Commission are not political but functional and relating to its successful operation, the purpose of which is free and fair elections at all levels in the country. The need of the day, therefore, is restructuring the Commission to suit the federal requirements.

IV

There is an urgent need to restructure the Commission, making it a statutorily multi-member body. Further, each state should be provided with a state election commissioner. Proper distribution of work and other necessary safeguards have to be worked out accordingly. To start with, all these appointments should be made by the President of India along the lines of the Chief Election Commissioner. Conditions of service and so on, should be similar to those of the CEC. There must be a clear distribution of functions and common procedures as have been laid down in the case of the judicial system. This would go a long way in strengthening decentralisation of election issues which can be sorted out on the spot and nearer to the electorate. There is also a need for a suitable amendment of the Representation of People's Act.

To say that several commissioners may lead to delay in decision-making is not tenable since the jurisdiction, functions, etcetera, would be clear and the aggrieved party would have an opportunity to approach the CEC on all election matters. An independent agency on the spot would ensure strict observance of the rules of the game, such as postings and transfers of personnel by the state executive either by way of punishment or reward.

It is therefore time for a serious debate to take place on the issue of making a comprehensive amendment to Article 324 in order to provide a multi-member Election Commission and state Election Commissions which would replace the existing arrangement.

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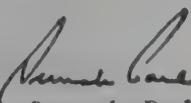
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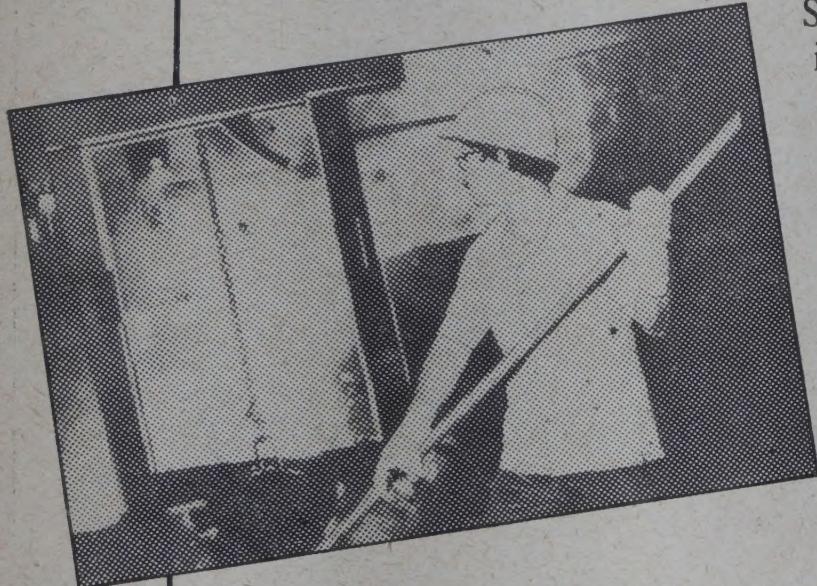
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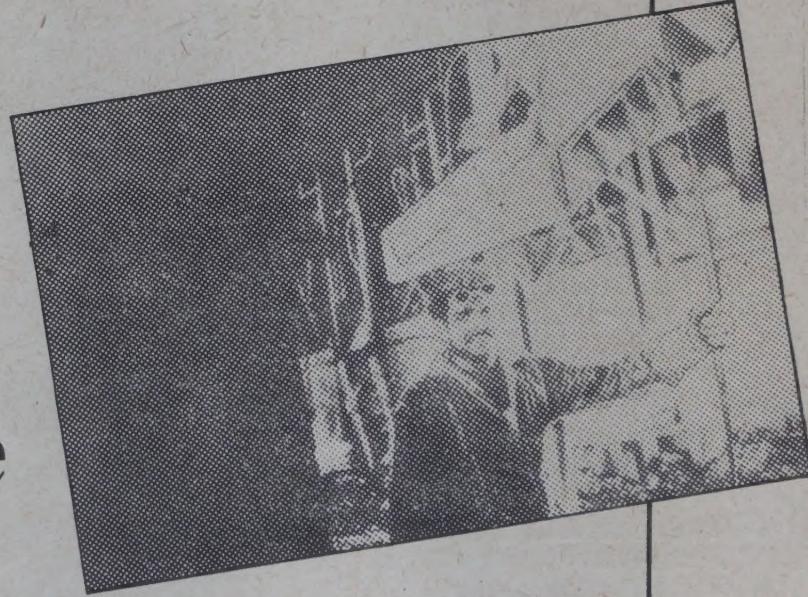
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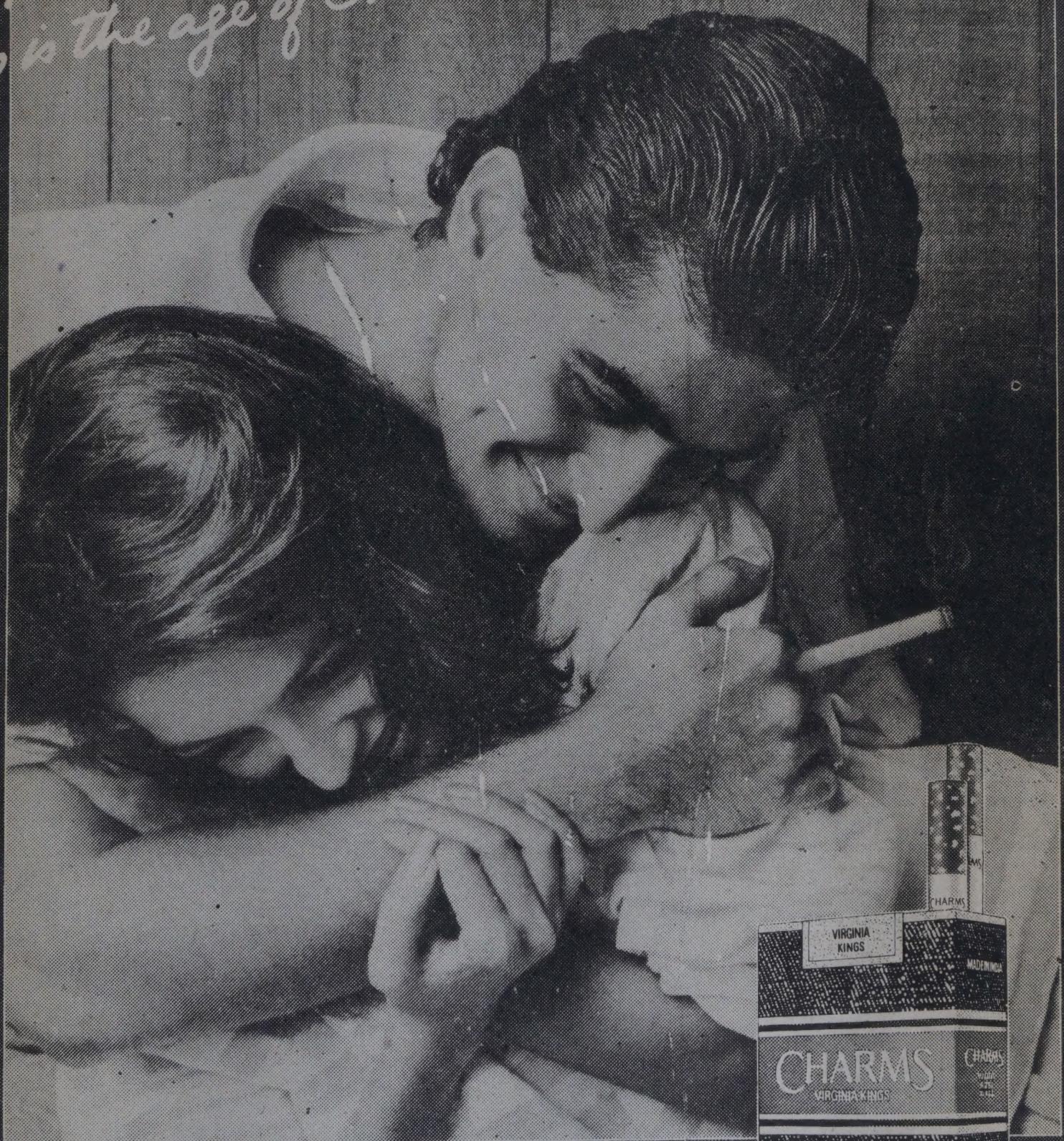


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